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* Mr. Justice Linden had just left the Commission at the time this working paper was approved, but he was involved in all the stages of its preparation. Judge Rivet was still a member of the Commission and Mr. Trevor-Deutsch was Project Co-ordinator. Madam Justice Picard and Professor Frémont joined the Commission after the document was approved.

Editor's Note

In keeping with the proposal advanced in *Equality for All: Report of the Parliamentary Committee on Equality Rights,* we have conscientiously endeavoured to draft this working paper in gender-neutral language. In doing so, we have adhered to the standards and policies set forth in *Toward Equality: The Response to the Report of the Parliamentary Committee on Equality Rights* pertaining to the drafting of laws, since the Commission's mandate is to make proposals for modernizing Canada's federal laws.

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Acknowledgements

The analysis in the following pages is based on information available in December 1990. However, the medical evaluation used as the starting-point for our study was completed in March 1990. Readers should bear these dates in mind.

We would like to thank the members of our Advisory Group of Experts on Health Law, which was officially consulted in November 1989. Needless to say, the views expressed in this paper do not necessarily reflect the positions of the group's individual members. The following individuals were consulted; they are listed in alphabetical order by field of expertise.

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Introduction

Technological development and the advancement of science, particularly medical science, constantly raise new challenges for our political and legal institutions. Social, moral, political and economic pressures force Parliament to systematically review the law and the practices arising therefrom. The law must take account of and promote scientific development, but must also impose the restrictions dictated by certain human and social values. Medically assisted procreation is perhaps one of the best examples of the challenges posed by the development of medical science and the tensions to which they give rise for the law.

National and world interest in medically assisted procreation reflects the importance ascribed to the risks, consequences and social and legal implications of the technologies being used. Whether the goal is to develop policies on reproductive technologies or reduce legal ambiguity,[1] society must reflect upon the choices to be made in view of existing conflicts and re-examine certain fundamental values and principles of law. Among issues of particular concern are the definition of the family; the filiation of children born as a result of medically assisted procreation; the commercialization of procreation, the human body and its products and substances; and the legal status of gametes and embryos. The potential and actual risks, both physical and psychological, raise concerns about public protection, including the protection of children born as a result of these technologies. We must therefore also consider the adequacy of the controls that apply to medically assisted procreation and the selection and storage of gametes and embryos.

However, developing a consistent national social policy on medically assisted procreation is not an easy task. The diametrically opposed views expressed in the reports of the Ontario Law Reform Commission[2] and the Barreau du Québec[3] on a number of fundamental aspects of the issue illustrate the problems. And the provisions in the Canadian Constitution on the distribution of powers between the federal government and the provinces do nothing to make matters easier.

The complexity and gravity of the issues raised by medically assisted procreation therefore demand careful consideration and serious discussion within Canadian society. It was

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1. Legal uncertainty can give rise to tremendous personal, family and social conflict. The American cases of *Baby M*, *infra*, note 302, *Davis* v. *Davis*, *infra*, note 203 and *York* v. *Jones Institute*, *infra*, note 204, as well as the *Rios* case involving orphaned embryos, *infra*, note 204, are good illustrations of this.

2. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters*, vols 1 and 2 (Toronto: Ministry of the Attorney General, 1985) [hereinafter OLRC].

3. Barreau du Québec, "Rapport du comité sur les nouvelles technologies de reproduction" (1988) 48:2 (Supp.) R. du B.

with this objective in mind that the federal government established the Royal Commission on New Reproductive Technologies.[4] The Commission was created for a specific purpose and is not intended to replace any permanent agency. Its mandate is to inquire into and report on current and foreseeable medical and scientific developments related to new reproductive technologies and their social, ethical, health, research, legal and economic implications. The Commission is also required to recommend policies and safeguards pertaining to a number of related issues.[5] It is to submit its report in October 1992.[6]

The Law Reform Commission of Canada undertook its examination of medically assisted procreation in an effort to advance the public debate and to complete its trilogy of studies in the area of medical law and procreation.[7] In May 1988, the task force set up by the Commission to review the status of the fetus recommended that the Commission inquire into the field of medically assisted procreation. In its working paper *Crimes against the Foetus* the Commission identified a number of issues that called for further research, among them surrogate motherhood, the need to establish national standards in view of the risk of interprovincial "procreative tourism" and to define the liability of donors who supply false information about their health status (genetic disorders, hereditary diseases, medical history) or who fail to provide pertinent information.[8] The Commission subsequently began a comprehensive study of the various technologies currently in use, and the phenomenon of surrogate motherhood.

The serious concerns that unsettle our society were also a factor in the Commission's decision to conduct this study. These concerns are often accompanied by demands for state

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4. P.C. 1989-2150, P.C. 1991-524. The Royal Commission was established under Part I of the *Inquiries Act*, R.S.C. 1985, c. I-11, which provides, *inter alia*, that commissioners are empowered to compel witnesses to appear (s. 4).

5. P.C. 1989-2150. The Commission's terms of reference include the following main issues:

   (a) implications of new reproductive technologies for women's reproductive health and well-being;

   (b) the causes, treatment and prevention of male and female infertility;

   (c) reversals of sterilization procedures, artificial insemination, in vitro fertilization, embryo transfers, prenatal screening and diagnostic techniques, genetic manipulation and therapeutic interventions to correct genetic anomalies, sex selection techniques, embryo experimentation and fetal tissue transplants;

   (d) social and legal arrangements, such as surrogate child-bearing, judicial interventions during gestation and birth, and "ownership" of ova, sperm, embryos and fetal tissue;

   (e) the status and rights of people using or contributing to reproductive services, such as access to procedures, "rights" to parenthood, informed consent, status of gamete donors and confidentiality, and the impact of these services on all concerned parties, particularly the children; and

   (f) the economic ramifications of these technologies, such as the commercial marketing of ova, sperm and embryos, the application of patent law, and the funding of research and procedures including infertility treatment.

6. P.C. 1991-524.

7. The first study dealt with criminal-law protection of the fetus: Law Reform Commission of Canada [hereinafter LRC], *Crimes against the Foetus*, Working Paper 58 (Ottawa: The Commission, 1989). The second dealt with biomedical experimentation on humans: LRC, *Biomedical Experimentation Involving Human Subjects*, Working Paper 61 (Ottawa: The Commission, 1989).

8. *Supra*, note 7 at 61. *Ibid.*: "Regulation of medical practice falls under provincial jurisdiction. In the absence of uniform, national accreditation procedures and limits of practice for institutions, the possibility of interprovincial 'procreative tourism' cannot be ignored and should be seriously examined."

intervention in the form of limits or controls justified by the scale of the costs involved, the need to impose limits on the development of medicine, the dangers of the marketing of procreation, the protection of the family unit and moral values, and the provision of safeguards against the exploitation of embryos, children, infertile couples and, especially, women.

Such demands are made by individuals and groups whose interests are sometimes at odds with the needs of those who are most directly involved (infertile or sterile individuals, physicians, scientists, and so on), and this can give rise to legal and social instability. In light of this instability and the inadequacy of other social controls,[9] legislative intervention may be needed to define and regulate the relationships between the parties and the social groups concerned and thus to restore social equilibrium. In this area, perhaps more than any other, we must be careful not to act too swiftly. The first step is to establish whether there is in fact a need for reform; only then can the scope of the change be determined.

Moreover, these social demands involve various aspects of the law which, needless to say, are of special interest to a law reform commission: law as an instrument of social change; law as a protector of the fundamental values of society; and law as a regulatory agent.

Our work centred around certain main themes. First, we examined the appropriateness of state intervention for purposes of limiting access to medically assisted procreation technologies or of controlling the use of such technologies. We considered the "problematic" medical aspects of the technologies and the ability of existing social and professional controls to provide adequate public protection (physical and psychological risks, selection, screening and storage standards, success rates, record keeping and access to medical and genetic information). We also looked at the need to review and, where necessary, adapt the law to the specific problems connected with the donation and deposit of gametes and embryos (ownership of genetic material and donor liability), and the filiation of the children involved. Finally, we examined the legal aspects of surrogate motherhood and the commercialization of procreation in general (sale of gametes and payments to surrogates).

Our study is divided into four chapters. The first two deal with the medical and legal aspects of the various technologies. The other two cover the role of the state and the reforms proposed by the Commission.

More specifically, chapter 1 explains the process involved in achieving pregnancy, the various kinds of infertility, and the technologies most often used to treat it. We will also discuss the genetic indications that may encourage the use of some of these technologies, and the risks and consequences associated with them. Particular attention will be paid to

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9. See chap. 3 regarding existing controls on medically assisted procreation. See chap. 2 regarding the shortcomings of positive law. See also Robert L. Kidder, *Connecting Law and Society: An Introduction to Research and Theory* (Englewood Cliffs, N.J.: Prentice-Hall, 1983), regarding the role of social forces.

success rates, the various ways of determining them and their effects on a couple's ability to choose the technology best suited to their situation. Finally, chapter 1 explains the various procedures used in gamete donation and the importance of donor selection.

Chapter 2 sets out the issues raised in Canadian law by the various situations made possible by the use of medically assisted procreation, in terms both of private law and of the rights protected by the *Canadian Charter of Rights and Freedoms*.[10] The main private law issues have to do with the legal status of gametes and embryos, the parentage of children born by means of new reproductive technologies, gamete donor liability, the liability of gamete and embryo banks and of physicians, the nature of surrogacy contracts, and the application of the principles of law with respect to the commercialization of the body, its products and substances. We will also study the influence of the *Charter* on state regulation of the use of medically assisted procreation technologies. In this connection, we will consider the question of the existence and limits of a possible constitutional right to procreate, and the influence of equality rights on the regulation of access to reproductive technologies. We will conclude with brief comments on the application of section 1 of the *Charter* in this context.

In order to determine the need for and the scope of possible state intervention in the area of medically assisted procreation, in chapter 3 we will deal with existing regulatory mechanisms, their scope and the role of the state.

In light of the analyses in the preceding chapters, chapter 4 will set out a series of proposals for reform designed to better define the interests at issue, to specify the rights and obligations of those involved in the use of reproductive technologies, and to create the necessary balance among the various values involved, such as respect for human dignity and respect for the individual rights and liberties of those concerned. We conclude our proposals with suggestions for putting in place a mechanism for implementing our recommendations.

Appendix A provides a description of the various measures recommended or adopted abroad — in particular Australia, the Council of Europe, Denmark, France, Germany, Norway, Spain, Switzerland, the United Kingdom, the United States — and, in Canada, at the federal level and in the common law provinces and in Quebec. Finally, appendix B provides a draft proposal indicating the structure that legislation governing the main aspects of medically assisted procreation might take.

We are aware that many of the questions raised in this study fall under provincial jurisdiction. But since they involve public health, the protection of certain fundamental values of our society, the protection of human life and bodily integrity, interprovincial and international trade, certain rights guaranteed by the *Canadian Charter of Rights and Freedoms*, and a clear need for uniformization, we believe that the federal government can and must play a major role as a catalyst in research and the development of a Canadian policy in the area of medically assisted procreation.

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10. Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11.

CHAPTER ONE

Medical Aspects of Medically Assisted Procreation

About 15 percent of couples seek medical assistance concerning fertility problems.[11] Whether this is a reflection of an increasing incidence of infertility over the years is subject to debate. What is not in debate, however, is that the adoption of infants is becoming increasingly difficult and can no longer be considered the alternative to childlessness it once was.[12] As adoption has become more difficult, the use of reproductive technologies and the medical treatment of infertility have become more widespread. In this first chapter, we present an overview of infertility and the reproductive technologies most commonly used to overcome it. These include artificial insemination (AI), in vitro fertilization (IVF) and gamete intrafallopian tube transfer (GIFT).

It is clear that some procedures are of more therapeutic value than others. Because the ability of infertile couples to choose the option most suited to them may be impaired by confusing reports of success, success rates are discussed in detail. Also explained are the procedures of gamete (sperm and egg) donation, and the importance of preventing the transmission of serious infectious and genetic diseases through adequate donor screening.

I. Achieving Pregnancy

Males produce sperm continuously throughout their reproductive lives. An ejaculation often contains more than 100 million sperm per millilitre. This is in sharp contrast to the total of 400 to 500 eggs that will be ovulated, usually one at a time, once a month, from puberty to menopause in a woman's lifetime.

In the sexually mature woman, several immature eggs (oocytes) begin to develop each month in the ovaries. Usually only one reaches maturity. A structure called the follicle houses and nurtures the maturing egg until it reaches maturity under the cyclic influence of hormones released from the pituitary gland. During ovulation the mature egg is released from the follicle, complete with protective coverings. After ovulation the follicle continues to function, secreting hormones (progesterone and estrogen) that are necessary in preparing the uterine lining (the endometrium) for implantation.

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11. Canadian Fertility and Andrology Society, *Guidelines for Therapeutic Donor Insemination* (Montreal: The Society, 1988) at 8.

12. OLRC, *supra*, note 2 at 16, where the decrease in the number of newborns available for adoption in Ontario is discussed. In 1982, for example, 73 infants were placed for adoption, compared to 961 in 1969.

Pregnancy depends on a series of events that must be successfully synchronized. Sperm must be deposited into the vagina in adequate numbers and must have sufficient motility to travel from the vagina through the uterus and unobstructed fallopian tubes to meet the egg that has been released from the ovary.[13]

The egg is receptive to fertilization for approximately 24 hours, after which it dies. The average life span of sperm is 48 hours (although fertilization may occur up to three or more days after insemination).[14] Conception is therefore possible during only a few days of the menstrual cycle.

Fertilization begins with contact between a spermatozoon and the egg, and ends with the union of maternal and paternal chromosomes (the male and female pronuclei). This occurs in the upper third of the fallopian tube. The cell resulting from the union of male and female pronuclei is referred to as a zygote, pre-embryo, or conceptus, and its genetic material is already different from that of its biological parents.

Approximately 30 hours after fertilization, cell division occurs for the first time and continues while the pre-embryo or conceptus is still traversing the fallopian tube. At about three days following fertilization, when the conceptus is at the 16-cell stage, it enters the uterus. Implantation in the uterine wall occurs between the sixth and tenth day after fertilization. The conceptus is now a hollow ball of cells referred to as the "blastocyst."[15]

Relatively few concepti result in babies. It has been estimated that more than 60 percent are lost prior to 12 weeks' gestation, and 90 percent of these losses occur before the first missed menstrual period without the knowledge of the mother.[16] The clinical spontaneous abortion rate or rate of miscarriage is about 15 percent in the general population.[17] Approximately 50 to 60 percent of these miscarriages are due to chromosomal abnormalities, a result of imperfect gametes or abnormal fertilization. Thus, the number of spontaneous abortions is to a large extent a natural form of protection against the continuation of an abnormal pregnancy.[18]

Consequently, in any given cycle of 100 ovulatory women who actually conceive, only 25 will become aware of pregnancy; of these, approximately four will have a miscarriage and about 21 go on to produce a live baby. This is why humans are said to be inefficient procreators; and, as we shall see, the fact that they are constitutes one of the most intractable problems of medically assisted procreation.

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13. For a complete discussion see Keith L. Moore, *Before We Are Born: Basic Embryology and Birth Defects*, 3d ed. (Philadelphia: W.B. Saunders, 1989) chaps 2 and 3.

14. The process of swimming through the uterus and into the fallopian tubes induces a process called capacitation, which is the final step in the maturation of sperm. Capacitation is essential for successful fertilization.

15. Keith L. Moore, *The Developing Human: Clinically Oriented Embryology*, 4th ed. (Philadelphia: W.B. Saunders, 1988) at 27-35.

16. D. Keith Edmonds, Kevin S. Lindsay, John F. Miller *et al.*, "Early Embryonic Mortality in Women" (1982) 38:4 Fertil. Steril. 447.

17. *Ibid.* This figure varies according to age. For an explanation of spontaneous abortion, see *infra* at 14.

18. Moore, *supra*, note 15 at 34.

II. Infertility

Infertility is the involuntary, significant reduction of reproductive capacity. In North America, the generally recognized threshold of infertility is an inability to become pregnant after one year of unprotected intercourse.[19] The World Health Organization's standard is two years.[20]

Although Canadian studies of infertility prevalence are scarce, it has been reported that 15 percent of couples seek medical advice for infertility.[21] In the United States the prevalence of infertility has not changed significantly from 13.3 percent in 1965 to about 13.9 percent in 1982, excluding surgically induced sterility.[22]

Some of the factors influencing the prevalence of infertility are:[23] (1) trends toward childbearing later in life;[24] (2) environmental factors, such as infection from sexually transmitted diseases, and occupational exposure; (3) medical treatments such as those used for high blood pressure, stomach ulcer and cancer, as well as non-therapeutic drugs such as narcotics, alcohol and tobacco.[25]

A. Evaluation of the Infertile Couple

The infertile couple seeking medical help undergoes a series of procedures to determine the nature and severity of the problem. First a medical history is taken and, if necessary, counselling about timing effective intercourse is given.[26]

The woman is tested to detect hormonal dysfunction. There may be a biopsy of the uterine lining, and a hysterosalpingogram, which is an X-ray that reveals blockages of the fallopian tubes. Laparoscopy, which is the introduction of an endoscope into the abdomen, may be used to inspect the outer surfaces of the uterus, fallopian tubes and

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19. Mary G. Hammond, "Evaluation of the Infertile Couple" (1987) 14:4 Obstet. Gynecol. Clin. N. Am. 821.

20. M.A. Belsey and Helen Ware, "Epidemiological, Social and Psychosocial Aspects of Infertility" in Vaclav Insler and Bruno Lunenfeld, eds, *Infertility: Male and Female* (Edinburgh: Churchill Livingstone, 1986) 631 at 632.

21. Canadian Fertility and Andrology Society, *supra*, note 11 at 8.

22. Congress of the United States, Office of Technology Assessment [hereinafter OTA], *Infertility: Medical and Social Choices* (Washington, D.C.: OTA, 1988) at 51-52.

23. For a discussion of the prevention of infertility see Masood A. Khatamee, "Infertility: A Preventable Epidemic?" (1988) 33:4 Int. J. Fertil. 246. Also, for a discussion of factors influencing infertility see *Infertility: Medical and Social Choices*, *supra*, note 22 at 61-82.

24. For statistics on Canadian trends towards childbearing later in life see A. Romaniuc, *Fertility in Canada: From Baby-boom to Baby-burst* (Ottawa: Statistics Canada, 1984) at 27-32. Also, the prevalence of infertility has been found to be about 10 percent higher in women over 35: see *Infertility: Medical and Social Choices*, *supra*, note 22 at 52.

25. R.J. Sokel, Y. Liel and S.M. Glick, "Medical Conditions Leading to Infertility" in Insler and Lunenfeld, eds, *supra*, note 20, 673 at 677-81.

26. Hammond, *supra*, note 19 at 821-27.

surrounding structures for any abnormalities. These procedures are often painful, include slight risks of infection, and may result in the puncture of the uterus, although this last is rare. Medical precautions, such as the administration of antibiotics, are therefore taken to minimize risks.[27]

The man must undergo a semen analysis to evaluate the number and quality of sperm. If the semen is abnormal, blood tests may be performed to detect hormonal abnormalities.[28] A post-coital test may also be used to determine if there is incompatibility between the semen and female reproductive factors. This test requires the couple to have sexual intercourse timed to coincide with ovulation; within a few hours, post-coital tests of cervical mucus are performed.[29]

B. Causes of and Treatments for Infertility

Infertility may be traced to one partner, both partners, or to biochemical or immunological incompatibility between partners. Most female infertility is due to: ovulation disorders, usually because of hormonal abnormality; tubal blockage[30] as a result of infection and other disease processes; endometriosis;[31] and other causes, including abnormalities of the vagina or cervix, and mucous incompatibilities with sperm.[32]

Treatments for female infertility include hormone or drug therapy, surgery, and medically assisted procreation technologies such as IVF and GIFT.

Infertility due to an ovulation disorder is treated with ovulatory stimulants, which are very successful if infertility is due only to an ovulation disorder.[33] Other medical

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27. For further discussion see Leon Speroff, Robert H. Glass and Nathan G. Kase, *Clinical Gynecologic Endocrinology and Infertility*, 4th ed. (Baltimore: Williams & Wilkins, 1989) chap. 17.

28. Serial studies of fertile men have demonstrated great variability in sperm counts of individuals over time, emphasizing that at least two or three sperm counts are often necessary before an accurate count can be assigned. See Richard F. Spark, *The Infertile Male: The Clinician's Guide to Diagnosis and Treatment* (New York: Plenum, 1988) at 130. See also David W. Keller, Ronald C. Strickler and James C. Warren, *Clinical Infertility* (Norwalk, Conn.: Appleton-Century-Crofts, 1984) at 100.

29. Hammond, *supra*, note 19 at 826.

30. Peter McComb, Victor Gomel and Timothy Rowe, "Investigation of Tuboperitoneal Causes of Female Infertility" in Insler and Lunenfeld, eds, *supra*, note 20 at 213.

31. The tissue that lines the uterus, the endometrium, grows abnormally outside the uterus in endometriosis. Approximately 10 percent of pre-menopausal women have endometriosis and about 30 percent of affected women are infertile. Precisely how this form of infertility occurs is unknown. See Ken Muse, "Clinical Manifestations and Classification of Endometriosis" (1988) 31:4 Clin. Obstet. Gynecol. 813.

32. K.S. Moghissi, "Diagnosis and Classification of Disturbed Sperm-Cervical Mucus Interaction" in Insler and Lunenfeld, eds, *supra*, note 20 at 299.

33. Janet L. Kennedy and Eli Y. Adashi, "Ovulation Induction" (1987) 14:4 Obstet. Gynecol. Clin. N. Am. 821 at 838-44. See *infra* at 12 and note 55 for a discussion of the common risks. Risks for multiple pregnancy are reported to range between 6 and 12 percent with the use of clomiphene and between 4 and 18 percent

treatments include drugs to treat endometriosis, infection, and immune incompatibilities. For fallopian tube blockage, surgery may be used.[34] When other infertility treatments are unsuccessful, artificially assisted procreation may be employed, but as a last resort.

Male infertility typically results from decreased numbers or an absence of sperm in the semen, abnormal motility and structural abnormalities, all of which prevent normal fertilization of the egg. Precise causes of male infertility are often undetectable, but varicocele (varicose veins of the testes) or infection may play a role.[35] The absence of sperm (azoospermia) may be caused by impaired production of sperm or blockage of passageways. Although greatly reduced numbers of sperm (oligospermia) reduce fertility, there is still controversy as to the number of sperm necessary for normal reproductive functioning.[36]

When sperm counts fall below five million, fertility is significantly reduced.[37] Therefore, couples unwilling to wait the several years often necessary to achieve "natural" pregnancy may seek treatment for male factor infertility. These treatments include hormonal therapy and such laboratory techniques as the "swim-up"[38] procedure that aim to improve the concentration of normal sperm available for fertilization. However, the success of these procedures in conjunction with the use of artificial insemination is less than 20 percent.[39]

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with the use of menotropin (Pergonal®). The risk of provoking "hyperstimulation syndrome" is greater with the use of Pergonal® than with clomiphene. It is a syndrome of varying severity, where a mildly affected woman (15 percent) will suffer enlarged ovaries and a severely affected woman (one percent) will suffer fluid shifts in the body which may be severe enough to cause shock. Her ovaries may enlarge to the extent that rupture is a possibility, requiring removal of the ovaries and, very rarely, death has been reported. Therefore close medical observation is required with the use of some ovulatory stimulants. See also Richard Borenstein *et al.*, "Severe Ovarian Hyperstimulation Syndrome: A Reevaluated Therapeutic Approach" (1989) 51:5 Fertil. Steril. 791.

34. See, for a review of indications, success and cost analysis, Ricardo Marana and John Quagliarello, "Distal Tubal Occlusion: Microsurgery versus In Vitro Fertilization — A Review" (1988) 33:2 Int. J. Fertil. 107. By the same authors see also "Proximal Tubal Occlusion: Microsurgery Versus IVF — A Review" (1988) 33:5 Int. J. Fertil. 338 at 338-40.

35. Spark, *supra*, note 28 at 129-33.

36. *Ibid.* Although a sperm count less than 10 million is considered unacceptably low, some pregnancies have occurred in partners of men with sperm counts below 5 million (*ibid.* at 129).

37. Erik Bostofte, Jorgen Serup and Heinrich Rebbe, "Hammen Semen Quality Classification and Pregnancies Obtained during a Twenty-Year Follow-up Period" (1981) 36:1 Fertil. Steril. 84.

38. The purpose of the "swim-up" procedure is to obtain the highest concentration of motile sperm possible by collecting sperm that have been placed in a container and have swum to the top of a special medium. Nancy J. Alexander and Steven Ackerman, "Therapeutic Insemination" (1987) 14:4 Obstet. Gynecol. Clin. N. Am. 905 at 909.

39. *Ibid.* at 911. A compilation of the literature reporting 812 cases of male factor infertility treated by means of AIH sperm yielded a pregnancy rate of 18 percent.

In theory, one might expect that IVF could be useful in the treatment of male factor infertility. Once the egg is placed directly in a container with the partner's sperm, the normal sperm, even if there are relatively few, should be able to fertilize the egg. This would provide the couple with a child genetically related to both parents. But the ability of the sperm to fertilize the egg appears to be only half as successful as in cases of IVF with non-male factors.[40] Nevertheless, there are reports that find IVF for male factor infertility as successful as IVF for other reasons.[41] In any event, artificial insemination by donor (AID) is considered a leading remedy for both the infertile and sterile male because it is less costly, less invasive, and statistically much more successful than IVF.[42]

III. Genetic Indications for Medically Assisted Procreation

Individuals who are not infertile but risk transmitting serious genetic diseases[43] or abnormalities may be considered "reproductively disabled" and are therefore candidates for medically assisted procreation. These individuals may require a donation of one or both gametes if the disease the gene of which they carry is not detectable through prenatal diagnostic techniques or if the couple is not amenable to the therapeutic abortion of an affected fetus. There are three types of transmissible genetic disease: an autosomal recessive disease such as Tay-Sachs disease or thallasemia;[44] an X-linked disease such as Duchenne muscular dystrophy or hemophilia;[45] or an autosomal dominant disorder such as Huntington's disease.[46] The presence of chromosomal (structural or numerical) abnormalities may also present significant risks for the offspring.

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40. *Ibid.* at 913. See also A. Acosta *et al.*, "The Role of In Vitro Fertilization in Male Infertility" (1988) 541 Ann. N.Y. Acad. Sci. 297 at 301; and Irvin Hirsch *et al.*, "In Vitro Fertilization in Couples with Male Factor Infertility" (1986) 45:5 Fertil. Steril. 659 at 662.

41. In selected populations of male factor infertility, IVF success is comparable to other indication for IVF. See Hirsch *et al.*, *supra*, note 40 at 663.

42. Alexander and Ackerman, *supra*, note 38 at 918ff.

43. Individually, genetic diseases are usually very rare, but when all genetic diseases are considered together, they account for more than 30% of all pediatric hospital admissions. Judith G. Hall, "Impact of Genetic Disease on Pediatric Health Care" in M.M. Kaback and L.J. Shapiro, eds, *Frontiers in Genetic Medicine: Report on the 92nd Ross Conference on Pediatric Research* (Columbus, Ohio: Ross Laboratories, 1987) 1 at 1.

44. Only when both partners carry the gene for an autosomal recessive disease is the offspring at risk. The disease occurs only if the offspring inherits both disease genes, one from each parent. The risk for disease occurrence is 25 percent for each pregnancy.

45. Also referred to as a sex-linked disease, the disease gene is located on the X chromosome and is most often passed on from an unaffected mother (who has two X chromosomes) to her son (who has one X chromosome along with a Y chromosome). Each son has a 50 percent chance of inheriting the disease, and each daughter has a 50 percent chance of inheriting the disease gene and becoming a carrier, usually without being affected herself.

46. If either parent carries the disease gene, each child will have a 50 percent chance of inheriting the disease.

IV. Medically Assisted Procreation Technologies

A. In Vitro Fertilization (IVF)

In 1878 the first attempts at in vitro fertilization were made using rabbits and guinea pigs. One hundred years after these first animal experiments, the first test-tube baby was born.[47] Since that time more than 3,000 children have been born worldwide as a result of IVF.[48] It is most commonly used when infertility is caused by blocked fallopian tubes, but is also used in some cases of endometriosis, and in male factor and unexplained infertility.[49]

By definition, in vitro fertilization implies the fertilization of an egg outside the future mother's body, or "in glass." The procedure is accomplished by removal of mature eggs from the ovary, fertilization in a container, and transfer of the early-developing concepti back into the uterus.

The IVF procedure involves five steps: (1) administration of superovulation drugs; (2) removal of one or more mature eggs from the ovary; (3) fertilization of one or more of these eggs outside the body; (4) incubation of the fertilized egg(s) until they are ready for transfer; and (5) transfer of early-developing concepti into the uterus.[50] The success of each step is contingent on the preceding one. Failure at any stage results in failure to become pregnant.

1. Superovulation

The probability of achieving pregnancy, and eventually live birth, increases when three or four embryos are simultaneously implanted in the uterus. Therefore, virtually all IVF programs throughout the world use drugs, individually or in combination, that induce the maturation and ovulation of more than one egg per cycle.[51]

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47. S. Fishel, "IVF — Historical Perspective" in S. Fishel and E.M. Symonds, eds, *In Vitro Fertilisation: Past, Present, Future* (Oxford: IRL Press, 1986) 1 at 1-16.

48. Machelle M. Seibel, "A New Era in Reproductive Technology" (1988) 318:13 New Engl. J. Med. 828.

49. *Ibid.* at 828-29.

50. The Reproductive Endocrinology and Fertility Committee, Society of Obstetricians and Gynaecologists of Canada, "In Vitro Fertilization and Embryo Transfer in Canada" (1987) 9:3 SOGC Bulletin 15 at 16-17 [hereinafter *IVF-ET Canada*].

51. The most common drugs used are clomiphene citrate (Clomid®), menotropins (Pergonal®), and human chorionic gonadotropins (HCG). *IVF-ET Canada, supra*, note 50 at 16. Gary D. Hodgen, "Physiology of Follicular Maturation" in Howard W. Jones, Jr., *In Vitro Fertilization — Norfolk* (Baltimore: Williams & Wilkins, 1986) 8 at 9. See also I.T. Cameron and D.L. Healy, "Patient Management" in Carl Wood and Alan Trounson, eds, *Clinical In Vitro Fertilization*, 2d ed. (London: Springer-Verlag, 1989) 11 at 15. For the risks involved with the use of these drugs, see *supra*, note 33.

Ovulation induction is successful approximately 80 percent of the time (an unsuccessful stimulation is referred to as a "cancelled cycle").[52] During treatment, patients are either admitted to hospital or outpatient facilities so that frequent blood samples can be taken to evaluate hormone levels and ultrasound monitoring of developing follicles may be carried out.[53]

Common side-effects of superovulation drugs include: hot flushes (10 percent), abdominal distention and pain (5.5 percent), breast discomfort (2 percent), visual disturbances (1.5 percent), headache (1.3 percent) and loss of hair (0.3 percent).[54] The "hyperstimulation syndrome" occurs rarely in IVF trials. The occurrence of this syndrome is minimized by medical precautions including the emptying of all the follicles, frequent ultrasound evaluations of ovaries and the control of blood hormonal levels.[55]

2. Egg Retrieval

Egg retrieval is performed with the aid of laparoscopy or ultrasound. In laparoscopy, the abdominal wall is punctured and the abdomen inflated with a gas mixture. This creates a space between the abdominal wall and the intra-abdominal organs. One or more tubes, including an endoscope, are then inserted into the space so that the surgeon can observe and manipulate the ovaries without having to make too large an incision. The mature eggs are then removed from the follicles. The main disadvantage of laparoscopy is that a general anesthetic is required, in addition to the use of several drugs during and after the laparoscopy to maintain the effect of the anesthetic and relieve pain. There has been concern regarding the effects of these drugs on the pregnancy, since it is known that they may enter the follicular fluid. Studies thus far, however, show no apparent effect on the outcome of the pregnancy.[56]

Ultrasound-guided retrieval of ova is often preferable to laparoscopic techniques because it is less invasive, and because a general anesthetic is not necessary.[57] Ultrasound employs high-energy sound waves, beamed from outside the body, to create images of internal organs and structures.[58] The surgeon uses the ultrasonic image of the ovary to guide a needle into the follicles through either the vagina, the urethra, or the abdominal wall.[59] Mature ova are then aspirated out of the ovary.

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52. Cameron and Healy, *supra*, note 51 at 15.

53. G.T. Kovacs, "Selection and Preparation of Patients for In Vitro Fertilization" in Wood and Trounson, eds, *supra*, note 51, 1 at 2.

54. Kennedy and Adashi, *supra*, note 33 at 838. See also Speroff, Glass and Kase, *supra*, note 27 at 591.

55. Daniel Navot *et al.*, "Risk Factors and Prognostic Variables in the Ovarian Hyperstimulation Syndrome" (1988) 159:1 Am. J. Obstet. Gynecol. 210 at 214. See also Cameron and Healy, *supra*, note 51 at 15. For a description of the syndrome, see *supra*, note 33.

56. J. Webster, "Laparoscopic Oocyte Recovery" in Fishel and Symonds, eds, *supra*, note 47 at 69. See also J. Leeton, "Oocyte Pick-up" in Wood and Trounson, eds, *supra*, note 51, 23 at 24.

57. Leeton, *supra*, note 56 at 24.

58. Lucy Frank Squire and Robert A. Novelline, *Fundamentals of Radiology*, 4th ed. (Cambridge: Harvard University Press, 1988) at 27.

59. Procedures that involve puncture of a full bladder to reach the ovary create the most discomfort, and limited relief is achieved from the use of a local anesthetic. Leeton, *supra*, note 56 at 25.

In terms of numbers and quality of recovered eggs, the laparoscopy and ultrasound methods are comparable. On average, four eggs are retrieved per cycle, but as many as 20 may be produced.[60]

Medical risks of egg retrieval include those inherent in the administration of a general anesthetic, if used. Also, there are risks of vaginal bleeding, pain, pelvic infection,[61] and the inadvertent puncture of blood vessels. There has been at least one death resulting from undetected bleeding following an egg-retrieval procedure.[62]

3. Evaluation of Eggs, Fertilization and Embryo Transfer

Recovered eggs are examined under the microscope for quality and maturity, so as to increase the likelihood of normal fertilization. A similar evaluation and preparation will already have been carried out on the sperm sample. The sperm is then added to a dish or test-tube containing the egg.[63]

If fertilization is successful, concepti are incubated. This induces cell division to the four-cell stage within approximately 44 hours. The concepti are transferred into the uterus at between the four- and eight-cell stage of development, after which the woman is discharged from the hospital and is usually encouraged to resume normal activity.[64]

4. IVF Success Rates

The difficulty in assessing the success of in vitro fertilization is that one clinic's criteria may not be comparable to another's. Criteria of success include the number of "chemical," "clinical," or "viable" pregnancies. These may be calculated on the basis of "treatment cycles," "egg retrievals," "embryo transfers" or number of women treated. The many combinations of "success" criteria can be confusing. To dispel the confusion, the definitions of each possible "numerator" and "denominator" should be understood.[65]

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60. P. Dellenbach *et al.*, "The Transvaginal Method for Oocyte Retrieval" (1988) 541 Ann. N.Y. Acad. Sci. 111.

61. The risk for pelvic infection, which may be severe, is reported to be about 3 percent and is reduced with the administration of antibiotics. See Robert S. Howe et al., "Pelvic Infection after Transvaginal Ultrasound-Guided Ovum Retrieval" (1988) 49:4 Fertil. Steril. 726 at 728.

62. Seibel, *supra*, note 48 at 829-30.

63. The concentration of sperm added to the egg(s) is much greater than that which would normally meet the egg in the fallopian tubes. See A. Trounson, "Fertilization and Embryo Culture" in Wood and Trounson, eds, *supra*, note 51, 33 at 33-47.

64. Seibel, *supra*, note 48 at 830-31. See also *IVF-ET Canada*, *supra*, note 50 at 17.

65. Hillary Page, "Calculating the Effectiveness of In-Vitro Fertilization: A Review" (1989) 96:3 Br. J. Obstet. Gynaecol. 334; A. Albert Yuzpe *et al.*, "Rates and Outcome of Pregnancies Achieved in the First 4 Years of an In-Vitro Fertilization Program" (1989) 140:2 C.M.A.J. 167 at 168.

5. Numerator Determination

A "chemical pregnancy," or preclinical miscarriage, is a pregnancy that is detectable by biochemical means (HCG determinations) but does not persist long enough to delay menstruation beyond 14 days. The pregnancy is not detectable clinically, no identifiable tissue is passed, and no medical action is necessary.[66]

A clinical pregnancy is a pregnancy detectable both by biochemical means and ultrasound, maintained until at least 28 days after egg retrieval.[67] These criteria would indicate that the conceptus has implanted and may be considered analogous to pregnancy by natural means. A pregnancy is considered "clinical" until the point of viability. If a clinical pregnancy is lost, it is considered a spontaneous abortion or miscarriage. Medical action may be required.

Finally, although the definition of viability may differ from jurisdiction to jurisdiction, a pregnancy is generally considered to be "viable" beginning 22 weeks after the last menstrual period.[68] The fetus is then considered capable of independent existence outside the mother's body.

The number of live births is probably the most important criterion of success, and certainly the numerator in which most couples treated are interested. It should be noted, however, that even this "bottom-line" figure can be confusing if the rate of multiple pregnancy is not clearly reported. For example, 100 live births does not necessarily mean that 100 couples will take home one baby each, since a substantial number of these live births will be births of twins, triplets, and so on. Therefore, some authors feel that reporting the proportion of deliveries relative to attempts would be the least confusing reflection of success because the chances of taking home at least one baby could be determined.

6. Denominator Determination

Couples must be made clearly aware of the variations and limits of reporting methods, so they can exercise fully informed consent to IVF.[69] For example, an IVF clinic may indicate that it has achieved a 20-percent pregnancy success rate.[70] As explained above, couples should first be informed what the denominator is: the hormonal treatment cycle? egg retrieval procedure? or embryo transfer (ET) procedure? Second, couples should be aware that a 20-percent pregnancy success rate per embryo transfer still does not necessarily reveal all the statistical and psychological realities of the process.

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66. Page, *supra*, note 65 at 334.

67. *Ibid.*

68. *Crimes against the Foetus, supra*, note 7 at 43 n. 93.

69. Fiona J. Stanley, "In-Vitro Fertilization — A Gift for the Infertile or a Cycle of Despair?" (1988) 148 Med. J. Australia 425.

70. See Kate Dunn, "Today — Cloned Cows. Tomorrow — You?" *The* [*Montreal*] *Gazette* (8 July 1989) A-1 at A-4.

Let us assume, for instance, that 200 couples enter an IVF clinic that claims a success rate of 20 percent per embryo transfer. Couples might reasonably conclude that 40 of the women are likely to become pregnant. In fact, many fewer are likely to do so because many couples will not reach the embryo transfer stage. At step one of the IVF process, the treatment cycle, some 40 of the original 200 couples will leave the program because, in general, 20 percent of IVF hormonal treatment cycles are unsuccessful.[71] Of the remaining 160 couples, another 24 (15 percent) will likely drop out prior to embryo transfer owing to difficulties at the egg retrieval and fertilization stages.[72]

This brings about 136 of the original 200 couples to the embryo transfer stage. Applying the clinic's stated 20-percent pregnancy rate per embryo transfer means that about 27 of the original 200 women will become pregnant, not 40 as one might reasonably expect. Statistically this translates into only a 13-percent pregnancy rate per treatment cycle (if this is the denominator chosen). Clearly, a "success rate of 20 percent," taken in isolation, is meaningless. The numerator and denominator must be known and must be the same in order for clinics to be compared with each other. Standardized methods of reporting success rates would greatly enhance couples' ability to make informed choices.

7. International Results

Table 1 (see *infra* at 35) gives recent statistics of national registries from Australia[73] (13 centres), the United States[74] (96 centres), and the United Kingdom[75] (42 centres). Because different reporting methods are used, it is difficult to establish a common criterion of "success." However, a crude measure of delivery rate (clinical pregnancies minus miscarriages and ectopic pregnancies) per hormonal treatment cycle may be instructive. Current data yield success rates of between six and nine percent. However, this is an overestimation of the "take-home baby" rate because stillbirths and early deaths of newborns are not considered.

Further, there is great variation in reporting methods among clinics. For example, in the United Kingdom, the Interim Licensing Authority (ILA) (formerly called Voluntary Licensing Authority) classifies data according to whether the centre is small, medium or large. The six large centres average a clinical pregnancy rate of 14.3, and 10 small centres

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71. See *supra*, note 52 and accompanying text.

72. Between 10 and 20 percent of patients who undergo egg retrieval do not reach the embryo transfer stage of IVF. H.W. Jones, Jr., and P.A.W. Rogers, "Results from In Vitro Fertilization" in Wood and Trounson, eds, *supra*, note 51, 51 at 57.

73. Australian In-Vitro Fertilization Collaborative Group, "In Vitro Fertilization Pregnancies in Australia and New Zealand, 1979-1985" (1988) 148 Med. J. Australia 429 [hereinafter *Australia IVF*]. See also Stanley, *supra*, note 69 at 425.

74. Medical Research International and the Society of Assisted Reproductive Technology, The American Fertility Society, "In Vitro Fertilization/Embryo Transfer in the United States: 1987 Results from the National IVF/ET Registry" (1989) 51:1 Fertil. Steril. 13 [hereinafter *U.S. IVF/ET 1989*].

75. *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990* (London: ILA, 1990) at 35-37 [hereinafter ILA].

average 9.2 percent.[76] In France there is also a disparity among clinics. As of April 1987, 17,000 oocyte recoveries were reported nationwide, resulting in 1,340 deliveries (7.8 percent). Although the number of pregnancies per embryo transfer generally was 14 percent, some clinics reported rates as high as 35 percent.[77] Individually published reports offer better success rates than those using compiled data.[78]

8. Canadian Results

IVF/ET programs have been in operation in Canada since 1982; currently there are 13 active programs. A recent report evaluating data from 11 Canadian centres between 1982 and 1988 showed that of 5,921 treatment cycles begun for 3,277 couples, a total of 460 live children were delivered. This translates into a rate of 7.9 percent live births per treatment cycle and 14.3 percent per couple treated.[79] Since multiple pregnancy rates were not reported, exact delivery rates cannot be calculated. Assuming, however, rates similar to those in other reports in the literature, it can be presumed that the take-home baby rate was about 20 percent less than stated success rates.

Reports from individual clinics in Canada are scarce.[80] One recent report from the University Hospital and the University of Western Ontario[81] summarized rates and outcomes of pregnancies from February 1, 1984 to December 31, 1987 at that centre. A clinical pregnancy rate of 12.3 percent per treatment cycle with a take-home baby rate per treatment cycle of 6.4 percent was reported.[82] The authors consider this to be an underestimation of current success rates, given recent improvements in technology.

A confidential voluntary national registry of pregnancies achieved by IVF or GIFT was begun at the Toronto East General Hospital in 1987.[83] This registry is incomplete because several centres have not submitted results.[84] More recently, the Ontario Medical Association has proposed guidelines (the first in Canada) to ensure the quality of IVF

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76. *Ibid.* at 20.

77. ESHRE (European Society of Human Reproduction and Embryology), Conference, October 1987, discussion, Michelle Plachot, J.P. Renard, Nicole Questiaux, J. Testart, speakers; R.G. Edwards, chair, "Discussion on Ethical and Judicial Aspects of Embryo Research" (1989) 4:2 Human Reprod. 206.

78. René Frydman *et al.*, "An Obstetric Assessment of the First 100 Births from the In Vitro Fertilization Program at Clamart, France" (1986) 154:3 Am. J. Obstet. Gynecol. 550; Geoffrey Sher *et al.*, "In Vitro Fertilization and Embryo Transfer: Two-Year Experience" (1986) 67:3 Obstet. Gynecol. 309.

79. See Stanley E. Brown, "In Vitro Fertilization — The Canadian Experience" (1989) 11:3 J. SOGC 27 at 28 and 31.

80. See *IVF-ET Canada*, *supra*, note 50 at 15. Two from among the few reports are Patrick J. Taylor *et al.*, "Initial Experience with In Vitro and Embryo Transfer at the University of Calgary/Foothills Hospital" (1985) 2:2 J. In Vitro Fert. Embryo Transfer 112; and Jacques-E. Rioux *et al.*, "Center for In Vitro Fertilization, Québec, Canada" (1984) 1:1 J. In Vitro Fert. Embryo Transfer 89.

81. Yuzpe *et al.*, *supra*, note 65 at 167.

82. *Ibid.* at 169-70. The rate of 6.4 percent was established on the basis of delivery and stillbirth rates.

83. See Note, "Canadian IVF Register" (1987) 9:3 SOGC Bulletin 19.

84. Personal communication, J. Tolentino and P. Phillips at the LIFE Program, Toronto.

services, including recommendations that a provincial registry be established and operated by the Ministry of Health. The registry would include details of parentage, success or failure rates, and pregnancy outcome. The guidelines recommend that this registry be confidential and available for peer review.[85]

9. Other Outcomes of IVF

Although the birth of a child is the first goal, IVF may have other outcomes: spontaneous abortion,[86] perinatal mortality and morbidity,[87] multiple[88] and ectopic[89] pregnancies, and Cesarean sections.[90] Rates for all of these are substantially higher in IVF pregnancies than in the general population.

(a) Multiple Pregnancies and Perinatal Risks

One in four women who have had successful IVF or GIFT treatment is delivered of twins or higher-order multiple births.[91] This is a much higher rate than is seen in the

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85. Ontario Medical Association, "OMA Guidelines for In Vitro Fertilization Programs in Ontario" (1990) 57:12 Ontario Med. Rev. 28.

86. According to the report, miscarriage rates are approximately 25 percent compared to 15 percent for the general population. See table 1, *infra* at 35.

87. Perinatal mortality is defined as the number of fetal deaths (stillbirths) and neonatal (newborn) deaths, from viability until 28 days after birth. Judith S. Mausner and Shira Kramer, *Epidemiology — An Introductory Text*, 2d ed. (Philadelphia: W.B. Saunders, 1985) at 92-93, 104-06. Perinatal morbidity refers to illnesses or defects of live-born infants during the same time span. See discussion in text at note 93, *infra*.

88. J. Cohen, M.J. Mayaux and M.L. Guihard-Moscato, "Pregnancy Outcomes after *In Vitro* Fertilization: A Collaborative Study of 2342 Pregnancies" (1988) 541 Ann. N.Y. Acad. Sci. 1 at 5. See also ILA, *supra*, note 75 at 19. The multiple pregnancy rate is about 20 percent compared to about one percent in the general population (rates of multiple pregnancies in the general population vary with race, age, and number of previous pregnancies). For a discussion of the epidemiology of multiple births see Jack A. Pritchard, Paul C. MacDonald and Norman F. Gant, *Williams Obstetrics,* 17th ed. (Norwalk, Conn.: Appleton-Century-Crofts, 1985) at 503.

89. An ectopic pregnancy is a pregnancy that occurs outside the uterus, usually in the fallopian tube, and is usually caused by a blockage of the fallopian tube that prevents the concepti from entering the uterus. The pregnancy in the fallopian tube may lead to a potentially life-threatening emergency that requires surgical removal of the affected tube. The ectopic pregnancy rate for IVF ranges between 4.5 and 7.5 percent compared to 1.5 percent in the general population. See table 1, *infra* at 35 for international rates.

90. Cohen, Mayaux and Guihard-Moscato, *supra*, note 88 at 3; and Yuzpe *et al.*, *supra*, note 65 at 170. Cesarean section rates are 47 and 72 percent for single and multiple pregnancies respectively, compared to general population statistics of 15 and 44 percent.

91. An international analysis of results of IVF and GIFT demonstrates a rate of multiple pregnancy of approximately 24 percent. See tables 1 and 2, *infra* at 35, 36. These figures represent national averages. It is well known, however, that individual unit rates will vary. For example, Yuzpe *et al.*, *supra*, note 65, report a multiple pregnancy rate of 16 percent and Frydman *et al.*, *supra*, note 78 at 552 and 554 report a multiple pregnancy rate of 12 percent.

general population, where the rate ranges between 1 in 80 to 95 births, although this is difficult to define precisely in the general population.[92]

A recent report from Australia concludes that pregnancies conceived through IVF and GIFT should be considered high-risk procedures because the perinatal mortality rate is three times that of the general population, and there is a high percentage of low-birth-weight infants. There are several contributing factors, such as the age of the mother and the infertility treatment itself. That said, 50 percent of the premature births and 70 percent of the low-birth-weight infants were associated with multiple pregnancies.[93] Of 460 live births resulting from IVF in Canada between 1982 and 1987, 21 died soon after birth (neonatal death). The majority of these were a result of premature birth, often associated with multiple pregnancies.[94]

Perinatal mortality is consistently higher in twins than in singleton (single baby) deliveries. In North America there are 14 to 16 deaths per 1,000 births for singletons. But for twins, perinatal mortality is reported to be four to seven times higher.[95] Thus, twin pregnancies, which represent only one percent of all births, account for 10 percent of all premature deliveries and 25 percent of pre-term deaths.[96] Associated with prematurity are breathing difficulties,[97] a predisposition to hemorrhages in and around the brain[98] and infection.[99]

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92. The actual rate of multiple pregnancies can be difficult to define because reporting methods vary internationally. See B.J. Botting, I. MacDonald Davies and A.J. MacFarlane, "Recent Trends in the Incidence of Multiple Births and Associated Mortality" (1987) 62 Arch. Dis. Child 941 at 942. Further complicating the analysis of the number of fetuses per *pregnancy* is the "vanishing twin" phenomenon, which describes the spontaneous reduction rate of twin pregnancies resulting in the loss of at least one of the fetuses. Early pregnancy ultrasound studies have demonstrated spontaneous reduction in fetuses to be similar to or higher than the spontaneous abortion rate in singleton pregnancies. Therefore, if IVF units report multiple pregnancy rates detected early in pregnancy, the rates will be greater than those reported at delivery time. See the discussion in Katharine D. Wenstrom and Stanley A. Gall, "Incidence, Morbidity and Mortality, and Diagnosis of Twin Gestations" (1988) 15:1 Clinics Perinatol. 1 at 2.

93. Douglas M. Saunders and Paul Lancaster, "The Wider Perinatal Significance of the Australian In Vitro Fertilization Data Collection Program" (1989) 6:2 Am. J. Perinatol. 252 at 252-53. See also *Australia IVF*, *supra*, note 73 at 433. Of 1138 live-born infants, 438 (38.5 percent) were from multiple births. See also Stanley, *supra*, note 69 at 425.

94. Brown, *supra*, note 79 at 28 and 31.

95. Joel I. Polin and William L. Frangipane, "Current Concepts in Management of Obstetric Problems for Pediatricians" (1986) 33:3 Pediatr. Clin. N. Am. 649 at 650. See also Wenstrom and Gall, *supra*, note 92 at 3, and Botting, MacDonald Davies and MacFarlane, *supra*, note 92 at 945.

96. See Polin and Frangipane, *supra*, note 95 at 650. See also Wenstrom and Gall, *supra*, note 92 at 4-5.

97. Respiratory Distress Syndrome (RDS) occurs most often in premature infants who are deficient in surfactant, a substance that promotes normal expansion of the lungs. This syndrome is especially prevalent (48 percent) in twins between 25 weeks' gestation and 32 weeks' gestation (between 15 and 8 weeks premature). See Wenstrom and Gall, *supra*, note 92 at 5.

98. Twins delivered between 25 and 32 weeks' gestation have at least a 20 percent chance of hemorrhaging into the ventricles of the brain. *Ibid.*

99. In infants weighing less than 2,500 grams the risk for Group B Streptococcal Disease was found to be five times greater in twins than in singletons. See Kristine McCulloch, "Neonatal Problems in Twins" (1988) 15:1 Clin. Perinatol. 141 at 151.

In addition to being prone to low birth weight because of prematurity, twins are also at increased risk for growth retardation.[100] Distress during labour, reduced oxygen (asphyxia), and ultimately stillbirth are all risks found in association with growth retardation.[101]

An international collaborative IVF study from 55 centres found the rate of birth defects to be only slightly higher for multiple births than for single births (3.6 compared to 2.5 percent).[102] However, studies of the long-term consequences of twin birth reveal a higher rate of learning disability, motor skill deficiency, speech problems, and delayed physical growth.[103] Risks to the mother during and following pregnancy include increased risk of pregnancy-induced high blood pressure, anemia, Cesarean birth and excessive bleeding after delivery.[104]

Approximately 15 percent of all multiple births associated with IVF are triplet or higher-order multiple pregnancies. Risks for both mother and fetus are greatly increased where there are more than two fetuses. For example, the perinatal mortality rate is approximately three times greater for triplets than for twins.[105]

(b) Lowering the Multiple Pregnancy Rate

Louise Brown was the first test-tube baby. Her birth in 1978 was the result of the in vitro fertilization of a single egg, retrieved during a natural cycle, and the transfer of the single conceptus back into the womb. In those early days, relatively primitive methods of predicting maturation and ovulation of the egg were imprecise. Retrieval of the ovum required the surgical team to be available around the clock, and even then the rate of successful retrieval was less than 50 percent. Failure at the fertilization and implantation stages compounded the problem of low success rates. In order to improve the odds, superovulation techniques were developed. They resulted in the capacity to induce several mature eggs per cycle, and better control of the timing of ovulation. Consequently, higher pregnancy rates were achieved.[106] However, as indicated above, the probability of

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100. Both terms, intra-uterine growth retardation (IUGR) and small for gestational age (SGA) describe fetuses/infants who are substantially smaller than their gestational age would indictate when compared to general population statistics of singleton fetuses. For example, a baby born after 35 weeks' gestation the size of an average 32-week baby would be considered growth retarded, and therefore at higher risk than one born at a size appropriate to its gestational period. See Polin and Frangipane, *supra*, note 95 at 657. See also Richard Bronsteen, Gregory Goyert and Sidney Bottoms, "Classification of Twins and Neonatal Morbidity" (1989) 74:1 Obstet. Gynecol. 98 at 100.

101. Polin and Frangipane, *supra*, note 95 at 657, and Bronsteen, Goyert and Bottoms, *supra*, note 100 at 100.

102. See Cohen, Mayaux and Guihard-Moscato, *supra*, note 88 at 3.

103. Wenstrom and Gall, *supra*, note 92 at 5, and Polin and Frangipane, *supra*, note 95 at 650-51.

104. Pritchard, MacDonald and Gant, *supra*, note 88 at 503.

105. Botting, MacDonald Davies and MacFarlane, *supra*, note 92 at 946.

106. G. Sher and H.C. Chotiner, "Controlled Ovarian Hyperstimulation for IVF" in Christopher M. Fredericks, John D. Paulson and Alan H. DeCherney, eds, *Foundations of In Vitro Fertilization* (Cambridge: Hemisphere, 1987) at 83.

multiple pregnancies and their attendant risks also increased. How, then, do we balance the maximum benefit derived from multiple transfers while minimizing the risk of multiple pregnancy? In other words, how many concepti should be transferred into the womb per cycle?

This question raises a number controversial issues, in particular the fact that there is no agreement as to an acceptable rate of multiple pregnancies.[107] Also, the relationship between the number of concepti transferred and the resulting number of multiple pregnancies is unclear, partly because of methods of reporting in the literature. One report, however, demonstrated that when four, five, six and seven embryos were transferred, the chances of delivering at least one baby were 18, 17, 18 and 18 percent, and the chances of multiple pregnancy were 16.7, 31.6, 50 and 50 percent respectively.[108] In other words, although the chance of delivering a baby was not greater with more than four embryos, the chance of multiple pregnancy increased substantially. Further, the same report demonstrated that the transfer of three embryos resulted in a birth rate of 12 percent, but in a multiple pregnancy rate of 21 percent.[109] A similar non-linear trend is seen in other reports (see table 3, *infra* at 36), demonstrating that pregnancy rate and multiple pregnancy rate are not determined solely by the number of embryos transferred.

Successful pregnancy is determined by the receptivity of the uterus to implantation and the "quality" of the embryos transferred.[110] At present, both uterine receptivity and embryo quality are difficult to quantify clinically. Further research is essential in this area to improve overall success rates in artificial reproduction while reducing the number of embryos that need to be transferred.[111] In the meantime, the most commonly accepted method of reducing the risk of multiple pregnancy is to limit the number of embryos transferred per treatment.

The limitation of embryo transfer has received international attention in the last few years. For example, national professional governing bodies in the U.K.[112] and in Australia have issued guidelines limiting to no more than three or (in extreme cases) four the number of embryos that may be transferred at any one time.[113] Not all practitioners have endorsed these guidelines. One British fertility team has resisted limitations, advocating a flexible approach for the number of embryos transferred in IVF or the number of eggs transferred

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107. Simon Fishel and John Webster, "IVF and Associated Techniques: Whom Can We Believe?" (1987) II:8553 Lancet 273.

108. *U.S. IVF/ET 1989, supra*, note 74 at 16.

109. *Ibid.*

110. Anibal A. Acosta *et al.*, "Implantation Potential of Each Pre-Embryo in Multiple Pregnancies Obtained by In Vitro Fertilization Seems to Be Different" (1988) 50:6 Fertil. Steril. 906.

111. Jan Tesarik, "Viability Assessment of Preimplantation Concepti: A Challenge for Human Embryo Research" (1989) 52:3 Fertil. Steril. 364.

112. See ILA, *supra*, note 75 at 22, and Ian Craft, Peter R. Brinsden and Eric G. Simons, "Voluntary Licensing and IVF/ET" (1987) I:8542 Lancet 1148.

113. C.R. Austin, "Voluntary Regulatory Scheme for Clinics Practising IVF and Related Technologies in Australia" (1989) 4:7 Human Reprod. 854. See also ILA, *supra*, note 75.

when using the GIFT procedure.[114] Professor Craft and his colleagues argued that limiting the number of eggs unfairly limited the chances of pregnancy in some cases; they argued that clinical judgment should prevail over strict enforcement, as is the case with most other medical procedures. For example, the chance of pregnancy and multiple pregnancy declines with advancing age,[115] perhaps warranting higher transfer numbers to achieve pregnancy. On the other hand, previous pregnancy increases the chance of multiple pregnancy. Therefore, individual risk for multiple pregnancy differs depending on such criteria as age and previous pregnancy. In addition, large variations in multiple pregnancy rates have been observed among clinics, even where the number of embryos transferred per cycle was the same.[116]

In Canada, individual clinics have policies regarding the numbers of embryos that may be transferred. Although most agree that the transfer of three or four embryos minimizes the chances of multiple pregnancy, freezing facilities are not always available for storing surplus embryos. Where adequate freezing facilities are available, surplus embryos may be frozen for future use by the couple. If the embryos are not eventually used, they may be donated, used for research or destroyed, depending on the wishes of the couple.[117]

Where freezing facilities are not available, the transfer of more than four embryos to the uterus may result in a higher-order pregnancy. If more than three embryos implant, the couple may be offered the option of selective fetal reduction.[118] Although the procedure has prompted ethical debate that both parallels and differs from the abortion issue,[119] it is generally agreed there is greater risk to all of the fetuses and to maternal health if the pregnancy continues intact than if the number of fetuses is reduced.

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114. Craft, Brinsden and Simons, *supra*, note 112; Ian Craft *et al.*, "Licensing Work on IVF and Related Procedures" (1987) I:8546 Lancet 1373; Ian Craft, "How Many Oocytes/Embryos Should Be Transferred?" (1987) II:8550 Lancet 109; Ian Craft *et al.*, "Multiple Pregnancy, Selective Reduction, and Flexible Treatment" (1988) II:8619 Lancet 1087.

115. Ian Craft *et al.*, "Analysis of 1071 GIFT Procedures — The Case for a Flexible Approach to Treatment" (1988) I:8594 Lancet 1094. Professor Craft's observation that multiple pregnancy occurs less frequently with increasing age is consistent with other reports. For example, Corson *et al.* state that the chance of multiple pregnancy declines by 9 percent per year after the age of 30. See Stephen L. Corson *et al.*, "Outcome in 242 In Vitro Fertilization-Embryo Replacement or Gamete Intrafallopian Transfer-Induced Pregnancies" (1989) 51:4 Fertil. Steril. 644 at 645. For a discussion of the effect of aging on IVF success, see also Santiago Padilla and Jairo E. Garcia, "Effect of Maternal Age and Number of In Vitro Fertilization Procedures on Pregnancy Outcome" (1989) 52:2 Fertil. Steril. 270.

116. A 12 percent multiple pregnancy rate was observed in an IVF program in France, compared to 25.4 percent observed in a program in Belgium, both units adhering to a policy that allows a maximum of three embryos transferred per attempt. See Frydman *et al.*, *supra*, note 78 at 553. See also P. Barlow *et al.*, "Early Pregnancy Loss and Obstetrical Risk after In-Vitro Fertilization and Embryo Replacement" (1988) 3:5 Human Reprod. 671 at 675.

117. For discussion of frozen embryos, see *infra* at 29; see also A. Trounson, "Embryo Cryopreservation" in Wood and Trounson, eds, *supra*, note 51, 127 at 138-39.

118. Selective feticide is referred to in the literature as selective reduction of fetuses, selective embryocide, selective abortion or selective birth. The procedure eliminates one or more fetuses in the pregnancy.

119. "Selective Fetal Reduction" (1988) II:8614 Lancet 773.

The risks associated with the reduction techniques include spontaneous abortion of the pregnancy, failure to destroy the fetus, risk of infection and, rarely, a clotting disorder that may threaten the remaining fetuses or the mother herself.[120] The emotional cost of selective fetal reduction to the mother, father, and existing children is unknown; therefore, counselling should perhaps be considered prior to or following the procedure or both.

Clearly, the problem of multiple pregnancies is one that requires more research. However, a promising experimental IVF procedure suggests it may be possible to reduce the multiple pregnancy rate to that of the general population. In one small trial, a 22.5-percent clinical pregnancy rate with an ongoing pregnancy rate of 17.5 percent per cycle was obtained using an unstimulated cycle;[121] this is as good as or better than results using superovulation techniques. By not using ovulatory stimulation drugs, the procedure eliminates risks associated with drugs.[122] Moreover, a better quality egg and optimum uterine receptivity are more likely to result from the natural cycle. Because the procedure involves minimal invasiveness, the possibility of more frequent, repeated attempts may provide a greater overall chance of pregnancy. Non-medical advantages include lower cost[123] and the elimination of ethical and legal issues regarding surplus embryos. It is too early, however, to tell whether these results will be found to be repeatable in other clinics. The main disadvantage of this procedure is failure to retrieve an egg in 10 to 30 percent of cases, and cancellation of cycles because of imprecise hormonal determinations.[124]

(c) Birth Defects

It is difficult to determine if rates of birth defects in infants conceived by means of IVF are higher than would be expected among infants conceived by natural means. Extraneous factors that could lead to a greater incidence of birth defects following IVF may include an older age group (risking chromosomal abnormalities and other hereditary defects), an increased number of multiple births, the underlying causes of infertility, and various clinical procedures including manipulation of gametes and embryos. Among 1,694

120. Ronald J. Wapner *et al.*, "Selective Reduction of Multifetal Pregnancies" (1990) 335:8681 Lancet 90 at 91. For a complete discussion of the history of the procedure and risks, see Fay O. Redwine and Patricia M. Hays, "Selective Birth" (1986) 10:1 Seminars Perinat. 73 at 75-78.

121. Fertility drugs are not used in the unstimulated cycle. The egg naturally matures and is retrieved, fertilized, and transferred, thereby eliminating concern regarding multiple pregnancy and surplus embryos. Hervé Foulot *et al.*, "In Vitro Fertilization without Ovarian Stimulation: A Simplified Protocol Applied in 80 Cycles" (1989) 52:4 Fertil. Steril. 617 at 617-21. See also Jairo Garcia, "Return to the Natural Cycle for In Vitro Fertilization (Alleluia! Alleluia!)" (1989) 6:2 J. In Vitro Fert. Embryo Transfer 67 at 67-68.

122. For a discussion of risks associated with ovulatory stimulation drugs, see Kennedy and Adashi, *supra*, note 33; see also *supra* at 8-9 and 12, and Navot *et al.*, *supra*, note 55.

123. The cost of the procedure is estimated to be reduced from US$6,000 to US$1,000 per attempt. See Garcia, *supra*, note 121 at 68.

124. Personal communication, Dr. E. Hughes, McMaster University, Hamilton, Ontario.

IVF births in Australia and New Zealand between 1979 and 1986, major congenital malformations, including chromosomal abnormalities, were reported at 2.2 percent (compared to 1.5 percent in the rest of the population).[125]

It has been suggested that the higher rate of abnormalities may have reflected observer bias, in that infants conceived by means of IVF might have been more carefully evaluated for abnormalities than children conceived naturally.[126] Therefore, it is suggested that large, systematic studies be carried out to determine if infants conceived using IVF are in fact at greater risk for malformation.

At the time this working paper was being prepared, Canadian congenital abnormality rates for infants conceived by IVF were not available.[127] It has been recommended that registries include this information when reporting outcomes of pregnancies conceived by artificial procreation.[128]

(d) Psychological Impact

The psychological impact of IVF procedures on couples is not apparent from a simple description of techniques and outcomes. One author who interviewed 20 Canadian women who underwent IVF found that for most of them the procedure was extremely stressful, both physically and emotionally. A profound fear of "cancellation" at each of the steps leading to embryo transfer prevailed. They also experienced "intense psychological conflict" between hopefulness and realism regarding their chances of achieving pregnancy.[129]

The stresses of infertility and IVF are such that, in Australia, legislation requires counselling both prior to and following IVF.[130] Indeed, Ontario Medical Association guidelines for IVF state that counselling should be available to all couples.[131]

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125. Paul A.L. Lancaster, "Congenital Malformations after In-Vitro Fertilisation" (1987) II:8572 Lancet 1392 (letter). Two types of birth defects, spina bifida (incomplete closure of the spine) and a serious heart abnormality (transposition of the great vessels), were significantly increased compared to the general population.

126. Eighty-three children conceived using IVF and 93 naturally conceived children were compared in a single-blind study. No statistically significant increase of abnormalities was seen. Although reassuring about large increases in abnormalities, the authors caution that the sample size was not significant enough to enable detection of small or moderate increases. See Norma C. Morin *et al.*, "Congenital Malformations and Psychosocial Development in Children Conceived by In Vitro Fertilization" (1989) 115:2 J. Pediatr. 222 at 226.

127. Brown, *supra*, note 79 at 31.

128. See ILA, *supra*, note 75 at 34. See also Ontario Medical Association, *supra*, note 85.

129. See Linda S. Williams, "No Relief until the End: The Physical and Emotional Costs of In Vitro Fertilization" in Christine Overall, ed., *The Future of Human Reproduction* (Toronto: Women's Press, 1989) at 120.

130. Paul Bravender-Coyle, "In Vitro Fertilization and the Law in Australia" (1986) 6:3 Health L. Can. 61 at 64.

131. Ontario Medical Association, *supra*, note 85 at 28.

B. Gamete Intrafallopian Transfer (GIFT)

In gamete intrafallopian transfer (GIFT), eggs and sperm are transferred, unfertilized, directly into the fallopian tubes.[132] Superovulation is practised because increased numbers of eggs improve the chance of successful pregnancy. With the use of a laparoscope, mature eggs are aspirated from the follicles, mixed with sperm, and placed in a syringe. The mixture is then transferred back deep into the fallopian tubes, allowing fertilization to occur naturally. The entire procedure takes approximately 35 to 60 minutes.[133]

This procedure is not indicated for those candidates with fallopian tube disease because of the risk of ectopic pregnancy.[134] Therefore, although indications for GIFT overlap those for IVF (unexplained infertility, endometriosis, male factor, cervical or immunologic reasons), they exclude the largest group of candidates for IVF, those with tubal disease.[135]

The primary advantage of GIFT is that the requirement for laboratory facilities is minimized. The major drawback is that a general anesthetic is necessary because of the laparoscopy. Thus, the invasiveness of the procedure is greater than with IVF as practiced in most centres. This may be a temporary problem, since some reports have shown that egg retrieval and transfer is possible using vaginal ultrasound-guided methods.[136] As technical mastery of this procedure becomes more widespread, the use of laparoscopy for GIFT should decline.

1. Success Rates

An international collaborative study of the first 800 cases of GIFT procedure, using a common GIFT protocol per egg retrieval, yielded a 34.4-percent clinical pregnancy rate and a delivery rate of 25 percent.[137] National reports from the U.S., U.K. and Australia demonstrated rates of clinical pregnancy ranging from 21 to 25 percent per transfer cycle,[138] which is higher than the 17- to 21-percent rate seen in IVF using a similar criterion of pregnancy.[139] Miscarriage rates were not provided in the U.K. data, so an ongoing pregnancy rate could not be calculated. However, an 18-percent delivery rate per egg retrieval was reported in the U.S. and Australian reports. The occurrence of multiple pregnancy is slightly higher than with IVF, ranging from 20 to 28 percent.[140]

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132. Seibel, *supra*, note 48 at 832.

133. R.H. Asch *et al.*, "Gamete Intrafallopian Transfer: International Cooperative Study of the First 800 Cases" (1988) 541 Ann. N.Y. Acad. Sci. 722 at 724.

134. See David L. Olive *et al.*, "Gamete Intrafallopian Tube Transfer (GIFT) Complicated by Bilateral Ectopic Pregnancy" (1988) 49:4 Fertil. Steril. 719 at 720.

135. See P.A.L. Lancaster, "Outcome of Pregnancy" in Wood and Trounson, eds, *supra*, note 51, 81 at 82; Asch *et al.*, *supra*, note 133 at 723; and Yuzpe *et al.*, *supra*, note 65 at 168.

136. R.P.S. Jansen, "Gamete Intra-fallopian Transfer" in Wood and Trounson, eds, *supra*, note 51, 63 at 72.

137. Asch *et al.*, *supra*, note 133 at 722-25.

138. See table 2, *infra* at 36.

139. See table 1, *infra* at 35. The clinical pregnancy rate is based on the number of embryo transfers.

140. See table 2, *infra* at 36 for details.

Once again, compiled national data reports demonstrate lower average success rates than those reported from individual centres.[141]

2. Complications

The collaborative study of 800 cases demonstrated no immediate major complications due to the procedure or to anesthesia, nor were any cases of induced pelvic inflammatory disease reported,[142] but the usual risks of anesthesia and laparoscopy remain. Although the ectopic pregnancy rate appears to be no higher than that seen in IVF,[143] it has been reported to be as high as 30 percent when undetectable tubal disease is present.[144]

C. Other Procedures

Several other variants of IVF and GIFT have been reported. These include peritoneal oocyte and sperm transfer (POST), pronuclear stage transfer (PROST), and tubal embryo stage transfer (TEST).

POST involves the transfer of oocytes and sperm through the posterior vaginal wall, by means of a needle, using the normal fluid in the abdominal cavity as a medium for transfer into the fallopian tube. PROST involves insemination of eggs in vitro and their transfer directly into the fallopian tubes. TEST is the transfer of early-stage embryos (frozen at a four-to-eight-cell stage[145]) into the fallopian tubes. None of these procedures has been used on a large scale, and they have not been reported from Canadian centres.

One variant of IVF and GIFT is referred to as IVC or intravaginal culture; this has been reported from a Canadian centre.[146] Eggs and sperm are placed in a small tube and allowed to incubate for about two days in the vagina of the recipient. The tube is held in place by a vaginal diaphragm. Later, the concepti are transferred into the uterus. This technique offers the advantage of simplifying laboratory manipulations and decreasing the cost of the procedure. A preliminary random study showed there was no difference in pregnancy rates between IVC and IVF.

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141. C. Borrero *et al.*, "The GIFT Experience: An Evaluation of the Outcome of 115 Cases" (1988) 3:2 Human Reprod. 227. See also Christopher J. Haines and Robert T. O'Shea, "Unilateral Gamete Intrafallopian Transfer: The Preferred Method?" (1989) 51:3 Fertil. Steril. 518 at 519.

142. Asch *et al.*, *supra*, note 133 at 724.

143. Ectopic pregnancy is reported to be between 3 and 6 percent, similar to reports of IVF but higher than the general population risk of 1.5 percent. See Asch *et al.*, *supra*, note 133 at 724; and Borrero *et al.*, *supra*, note 141 at 228. See also *supra*, note 89.

144. Jansen, *supra*, note 136 at 73.

145. See John L. Yovich, Jeanne M. Yovich and W. Rohini Edirisinghe, "The Relative Chance of Pregnancy Following Tubal or Uterine Transfer Procedures" (1988) 49:5 Fertil. Steril. 858 at 859-60 for a description of PROST and TEST. See also Vinay Sharma, Bridgett Mason and Stuart Campbell, "Ultrasound-Guided Peritoneal Oocyte and Sperm Transfer" (1988) 541 Ann. N.Y. Acad. Sci. 767 (Discussion of POST).

146. Claude Ranoux *et al.*, "A New In Vitro Fertilization Technique: Intravaginal Culture" (1988) 49:4 Fertil. Steril. 654 at 656.

D. Artificial Insemination

The first successful cases of artificial insemination, the simplest and oldest of the reproductive technologies, were first reported in the literature in the 1770s.[147] It is currently estimated that in North America between 10,000 and 20,000 infants are conceived each year as a result of artificial insemination.[148] As a solution to male infertility, it is simple, non-invasive and relatively inexpensive, although some new AI procedures are beginning to approach the levels of invasiveness of other reproductive procedures.[149]

Artificial or therapeutic insemination may be performed using the sperm of the husband/partner (AIH) or of a sperm donor (AID). AID is most often performed after male infertility has been established and medical treatment has been unsuccessful.[150] Donor sperm is also indicated in some cases where either partner is carrying a genetic disease.[151]

Artificial insemination by the husband/partner is indicated in fewer than 20 percent of couples where male infertility is present. In some, bypassing of the vaginal secretions by the sperm may be sufficient to allow fertilization. Other indications for AIH include anatomic abnormalities of the male, such as hypospadias, where the opening of the urethra is situated in a place other than the end of the penis, or a maternal abnormality such as a malpositioned uterus.[152]

1. The AI Procedure

It is generally accepted that donor sperm should be frozen prior to use. Frozen sperm is recommended because screening can be done to reduce the risk of transmitting infectious

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147. For a discussion of the history of AI, see Derek J. Jones, "Artificial Procreation, Societal Reconceptions: Legal Insight from France" (1988) 36 Am. J. Comp. L. 525 at 530-33.

148. Barbara Eck Menning, "The Psychology of Infertility" in James Aiman, ed., *Infertility: Diagnosis and Management* (New York: Springer-Verlag, 1986) 17 at 23. Also, a 1981 Canadian report stated that about 500 inseminations were done each month at Canadian clinics and more than 1,500 babies had been born at that time as a result of AID. See *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (Ottawa: Health and Welfare Canada, 1981) at x-xi [hereinafter *Report on Human Sperm 1981*].

149. DIPI, or Direct Intraperitoneal Insemination, is a procedure in which sperm is deposited by means of a needle and tube, through the posterior portion of the vagina into a space containing fluid near the ovaries and the fallopian tube, thus bypassing the uterus. See P. Dellenbach *et al.*, "Direct Intraperitoneal Insemination: New Treatment for Cervical and Unexplained Infertility" (1988) 541 Ann. N.Y. Acad. Sci. 761. See also Jansen, *supra*, note 136 at 72.

150. Alexander and Ackerman, *supra*, note 38 at 907-08.

151. Between 1 and 10 percent of AI is performed to prevent the inheritance of a genetic disease. See James Aiman "Artificial Insemination" in Aiman, ed., *supra*, note 148 at 277. Also see Pierre Jalbert *et al.*, "Genetic Aspects of Artificial Insemination with Donor Semen: The French CECOS Federation Guidelines" (1989) 33 Am. J. Med. Genet. 269 at 272.

152. Keller, Strickler and Warren, *supra*, note 28 at 203-04.

diseases such as AIDS,[153] availability of specimens from the same donor for repeated inseminations is increased, and possibilities are better for the matching of recipient characteristics with donors.[154]

The storage of sperm for future use by an individual male is another reason that sperm may be frozen. For example, permanent destruction of the capacity to produce sperm can be a side-effect of radiation therapy for some cancers.[155] Therefore, banking of sperm prior to radiation may be desirable.

Insemination is the delivery of sperm through a syringe into the vagina, the cervix, or the uterus. Improved rates of pregnancy have been achieved using an ultrasound-guided tube to deposit sperm directly into the fallopian tube, but this procedure is still experimental.[156]

Timing is essential to the success of artificial insemination. Since sperm survives approximately 48 hours, one insemination one to two days prior to the expected time of ovulation, and another insemination 48 hours later, should provide sufficient coverage of the fertile interval.[157] The timing of ovulation can be determined with a certain accuracy by the charting of body temperature, ultrasound measurement of follicular growth, and measurements of hormone levels.[158]

2. Outcomes

Most studies of clinical pregnancy rates for AID employed fresh (that is, unfrozen) semen samples. These are comparable to results achieved with natural insemination: about 20 percent per cycle, approaching 95 percent by the end of six cycles. Studies have demonstrated that freezing sperm reduces its motility, longevity and fertilizing capacity by half. Cumulative pregnancy rates are approximately half those expected with fresh semen, and several more treatment cycles, on average, are necessary to achieve conception using frozen sperm.[159] The rate of spontaneous abortions, however, is not elevated where frozen sperm is used.[160] As with other artificial reproductive techniques, pregnancy rates are influenced by maternal age and fertility.[161]

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153. See discussion *infra*, note 181.

154. Alexander and Ackerman, *supra*, note 38 at 919.

155. Philip Rubin and Richard F. Bakemeier, *Clinical Oncology: A Multidisciplinary Approach*, 6th ed. (New York: American Cancer Society, 1983) at 352. See also Jones, *supra*, note 147 at 527.

156. Jansen, *supra*, note 136 at 72.

157. Keller, Strickler and Warren, *supra*, note 28 at 211, and Aiman, *supra*, note 151 at 282.

158. Aiman, *supra*, note 151 at 281-82.

159. The French Federation CÉCOS (Centres d'études et de conservation du sperme humain) has collected data on about 17,000 pregnancies achieved using frozen sperm. The success rate per cycle is about 8 percent, with a cumulative success rate of 66 percent at 12 months. See D. Le Lannou and J. Lansac, "Artificial Procreation with Frozen Donor Semen: Experience of the French Federation CÉCOS" (1989) 4:7 Human Reprod. 757 at 759.

160. Jon Alfredsson, "Incidence of Spontaneous Abortion Following Artificial Insemination by Donor" (1988) 33:4 Int. J. Fertil. 241 at 244.

161. Le Lannou and Lansac, *supra*, note 159 at 760. See also Christopher L.R. Barratt, Mayur Chauhan and Ian D. Cooke, "Donor Insemination — A Look to the Future" (1990) 53:3 Fertil. Steril. 375 at 382.

The indication for AIH will determine the success rate: AIH is the least effective fertilization technique if the problem is with the husband's/partner's sperm.[162] However, couples treated because of male anatomical abnormality will have high success rates.

3. AI Risks

The main risks associated with AID are: infection; transmission of genetic disease; consanguinity, if the same donor is used too many times in a small centre;[163] administration errors in matching donor with recipient; and risks associated with intra-uterine insemination.

The risk of infection increases when the semen is introduced into the cervix and the uterus. Untreated semen may contain disease-causing organisms such as the gonococcus, chlamydia or HIV. The practice of storing sperm until adequate screening can be done greatly reduces the risk of infectious-disease transmission.[164]

Women receiving intra-uterine insemination either by donor or husband may experience uterine contractions and, more rarely, low blood pressure, slowed heart rate and weakness. Medical precautions can be taken to minimize such effects.[165]

The risk of genetic-disease transmission is reduced if donors are adequately screened, enabling the couples to be informed, prior to acceptance, of potential risks for genetic disease in their offspring. This is discussed more fully elsewhere in the text. Consanguinity risks are minimized where donors are "retired" after a number of donations. The smaller the size of the community served by a clinic, the fewer times an individual should be permitted to donate sperm.

4. Donors

The usual practice is that sperm donors are anonymous to recipients. Medical students and other university students often act as sperm donors, perhaps because of their proximity to fertility clinics. However, in some places sperm donors may be sought through advertisements in the media.[166] Canadian centres usually operate their own sperm banks and in some circumstances may also import sperm from such places as New York and California.[167]

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162. Spark, *supra*, note 28 at 336. See also *supra*, note 39.

163. If the same donor is used too many times, theoretically there is a risk that biologically related offspring, without knowledge of paternity, may meet and reproduce, risking genetic abnormality to their offspring. In fact, it has been calculated that the risk of two half-siblings (resulting from AID in a large centre) meeting and reproducing is extremely low (less than 1/1000). Aiman, *supra*, note 151 at 284. The risk of consanguinity would depend on the size of the community served.

164. See "Screening Gamete and Embryo Donations," *infra* at 32.

165. These effects can often be reversed with the use of aspirin. See Aiman, *supra*, note 151 at 284.

166. Canadian Fertility and Andrology Society, *supra*, note 11 at 5.

167. See *Report on Human Sperm 1981*, *supra*, note 148 at 13ff.

E. Ovum and Embryo Donation

Ovum donation is becoming an increasingly popular reproductive option for some sterile individuals, for example those with premature menopause. In 1987, in fact, 17 U.S. centres reported using donated eggs for IVF/GIFT procedures as compared to only one centre in a 1985-86 report.[168] Ovum donation is most often indicated where the recipient's ovaries are absent or malfunctioning, or where she is carrying a gene for a genetic disorder.[169]

Embryo donation is the practice of donating an embryo that is genetically unrelated to the recipient couple. Embryos may be available for donation from those undergoing IVF where there is an excess number of embryos for their own purposes.

Embryo freezing both creates and diminishes medical and legal ethical dilemmas. Embryo freezing delays but does not eliminate the burden of disposal of embryos which, if not used, will have to be dealt with eventually. The main advantages of embryo freezing are that: the procedure allows for a limitation of the number of fresh embryos reimplanted in an IVF cycle, therefore reducing the risk of multiple pregnancy; if the first IVF cycle is not successful, it allows for future attempts in natural cycles without further egg retrieval; it allows for simplified development of embryo-donation programs.

Limited cell damage is allowable during the freeze-thaw procedure without detrimental effects on the early conceptus because at this stage all cells have the capacity to develop fully into an embryo. Therefore, a conceptus frozen at the four-cell stage may survive the thawing procedure with three cells remaining and yet retain normal developmental potential.[170]

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168. *U.S. IVF/ET 1989*, *supra*, note 74 at 17. See also Medical Research International and American Fertility Society Special Interest Group, "In Vitro Fertilization/Embryo Transfer in the United States: 1985 and 1986 Results from the National IVF/ET Registry" (1988) 49:2 Fertil. Steril. 212 at 214 [hereinafter *U.S. IVF/ET 1988*].

169. J. Leeton, A. Trounson and C. Wood, "The Use of Donor Eggs and Embryos in the Management of Human Fertility" (1984) 24:4 Aust. N.Z. J. Obstet. Gynaec. 265.

170. Trounson, *supra*, note 117 at 140. An international survey of 24 centres, completed in December 1986, showed that of 3577 frozen embryos, approximately 50 percent were suitable for replacement. A 13-percent pregnancy rate per transfer and a 26-percent spontaneous abortion rate were demonstrated. The delivery rate was unclear, since singletons were not differentiated from multiple pregnancies. André C. Van Steirteghem and Etienne Van Den Abbeel, "Survey on Cryopreservation" (1988) 541 Ann. N.Y. Acad. Sci. 571. For further information on success rates for pregnancies achieved through the use of frozen embryos, see Jacques Testart, "Results of In Vitro Fertilization with Embryo Cryopreservation and a Recommendation for Uniform Reporting" (1988) 49:1 Fertil. Steril. 156.

1. The Ovum Donation Procedure

General egg retrieval procedures have been described elsewhere in this chapter.[171] Methods of egg retrieval by lavage have been described in the literature, although they are not used in Canada. This involves the donor undergoing superovulation, with or without insemination. Eggs or concepti are flushed from the uterus with a solution.[172]

If the recipient has normal ovulatory cycles, the cycles of the donor and recipient must be synchronized to ensure that the uterine lining of the recipient is ready for implantation. If the recipient does not have normal cycles, as in premature menopause, hormones are administered to mimic a normal cycle. At the time of transfer of the concepti or gametes, the recipient's hormonal levels must be sufficient to allow implantation, and must be maintained until the placenta of the developing embryo takes over the task of producing the hormones that maintain pregnancy, approximately 8 to 12 weeks later.[173]

2. Ovum Donors

The potential pool of ovum donors consists of: women undergoing egg retrieval for their own reproductive purposes; women undergoing sterilization; volunteer, anonymous donors; and known donors (friends or relatives recruited by the recipient).[174]

The process of superovulation and egg retrieval carries with it a small medical risk. Whether this risk is reasonable when donation occurs for purely altruistic reasons is still the subject of debate. Those undergoing the procedure for their own reproductive purposes, where the number of eggs obtained is in excess of individual needs, are probably the most suitable candidates for donation. The availability of eggs through this source becomes limited, however, where freezing facilities are available, because couples undergoing egg retrieval are likely to choose to have excess eggs fertilized, and the concepti frozen for their own future use.[175]

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171. *Supra* at 12-13.

172. Mark V. Sauer, Robert E. Anderson and Richard J. Paulson, "A Trial of Superovulation in Ovum Donors Undergoing Uterine Lavage" (1989) 51:1 Fertil. Steril. 131. The method of concepti donation following superovulation, insemination and lavage is considered unacceptable in some jurisdictions because of the substantial risk of unwanted pregnancy to the donor. See P.A.W. Rogers *et al.*, "Oocyte Donation" in Wood and Trounson, eds, *supra*, note 51, 143 at 146.

173. Rogers *et al.*, *supra*, note 172 at 148-51.

174. *Ibid.* at 145-46.

175. Freezing of eggs is not an established practice at this time, although four children have been born worldwide with the use of frozen-thawed eggs. The human egg is especially vulnerable to damage during the freeze-thaw process. The risk is of abnormality during subsequent cell division, resulting in an abnormal number of chromosomes; also, the protective coverings surrounding the egg may be damaged, allowing more than one sperm to fertilize the egg. More study is needed in this area to determine if there is indeed a future in the freezing of human eggs. Trounson, *supra*, note 117 at 138-39. See also Christopher Chen, "Pregnancies after Human Oocyte Cryopreservation" (1988) 541 Ann. N.Y. Acad. Sci. 541 at 547.

Known donors are used frequently.[176] The literature suggests that caution should be exercised, in that the future of the psychological relationship between the child, the birth mother and the egg donor is an important consideration.[177] Further, if egg donation is employed to avoid transmission of genetic disorders, family members may not be appropriate donors. To avoid a substantial risk of genetic abnormality due to consanguinity, the husband's sister is not a suitable candidate except when donor sperm is used.

Finally, women undergoing sterilization procedures are suitable donors.[178] In these cases, individuals have already decided to undergo the invasive procedure of sterilization; therefore the only added risk is that of superovulation.

F. Surrogacy

In the context of this working paper, a surrogate is a woman who agrees to gestate a pregnancy with the intention of surrendering the newborn infant to the "social" or "contracting" parents. Leaving aside the important ethical and legal issues to which this phenomenon gives rise, there are three general medical circumstances in which surrogacy may be indicated:[179] (1) absence or significant abnormality of the uterus (where surrogacy would be the only possible way of producing a child); (2) cases in which there is environmental risk to the developing fetus (such as when the mother, for her own health, must on a continuing basis take medications that may be harmful to a developing fetus); or (3) when pregnancy poses a substantial threat to maternal health, as in the case of severe heart disease. The latter two situations suggest a safer environment for pregnancy, but are not considered absolute indications.

There are several possible combinations of parentage between the surrogate and future parents. The egg may originate from the surrogate or the contracting woman or it may be donated by a third party. The sperm may be the contracting father's or it may be donated sperm. In all, six combinations of biological parentage are possible.

Methods of fertilization nearly as numerous can be classified under two categories: (1) in vitro fertilization; and (2) in vivo fertilization, including GIFT, artificial insemination, and natural insemination. In vitro fertilization and GIFT are more likely to be used in cases where the egg is not contributed by the surrogate.

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176. Mark V. Sauer *et al.*, "Survey of Attitudes Regarding the Use of Siblings for Gamete Donation" (1988) 49:4 Fertil. Steril. 721.

177. See discussion ILA, *supra*, note 75 at 15. After a multidisciplinary meeting about egg donation, it was decided that, like sperm donors, egg donors should remain anonymous (*Authority's Guideline* 13(j), *ibid.* at 47).

178. Rogers *et al.*, *supra*, note 172 at 146. An added advantage of this group as donors is that their fertility has in most cases already been demonstrated.

179. For a discussion of pregnancy that poses substantial risk to the mother or the fetus, see Pritchard, MacDonald and Gant, *supra*, note 88 at 494, 592, 608 and 802.

Surrogate embryo transfer (SET), in which the egg of the donor is fertilized in vivo by artificial insemination, collected by lavage and transferred to the gestational mother, is sometimes included under the category of surrogacy, but in this chapter it is discussed under the heading of ovum and embryo donation.[180]

V. Screening Gamete and Embryo Donations

Sperm donation is now a well-accepted palliative to infertility, and with the further development of simpler egg-retrieval techniques it is foreseeable that ovum donation will also become widely used. The major risk to the recipient associated with gamete donation is the transmission of infectious diseases. For the resulting offspring, the risks are not only of infectious disease (such as cytomegalovirus), but also of genetic abnormality. Although the merits of screening for both infectious and genetic diseases have been widely discussed and internationally advocated, there is reasonable concern that some clinics may choose not to follow recommendations for screening[181] established by such professional groups as The American Fertility Society[182] and the Canadian Fertility and Andrology Society.[183]

The probability of transmitting the AIDS virus through donated semen, although very rare, has led to firm recommendations that all donor semen in Canada be frozen and stored for at least six months, until the donor is retested for evidence of the virus. This is necessary because evidence of seropositivity in the donor's blood may not be detectable for some time after exposure.[184]

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180. See *supra*, note 172.

181. A survey of 11,000 physicians participating in AID in the U.S., completed in 1987, found that one-fifth of centres surveyed did not screen donors for sexually transmitted diseases and fewer than half screened for genetic diseases. Further, of those that did screen for genetic diseases, many did not screen appropriately; for example, donors were rejected unnecessarily in some cases and in other cases accepted when there was significant risk. See OTA, *Artificial Insemination: Practice in the United States* (Washington, D.C.: OTA, 1988) at 8, 33-40. Also, in 1984 an Ontario Law Reform Commission survey of 16 physicians performing AID in Ontario found that donor screening practice varied considerably. See OLRC, *supra*, note 2 at 22 n. 36-38; see also Barratt, Chauhan and Cooke, *supra*, note 161.

182. The American Fertility Society, "New Guidelines for the Use of Semen Donor Insemination: 1990" (1990) 53:3 (Supp. 1) Fertil. Steril. 1Sff; see also *infra*, note 186.

183. Canadian Fertility and Andrology Society, *supra*, note 11 at 3. Guidelines for Therapeutic Donor Insemination were adopted in October 1988, stating: "Rigorous attention must be paid to all aspects of donor screening and management to reduce the risks of transmitting genetic or other diseases to the recipients to the absolute minimum possible level in accordance with all currently available screening and testing procedures."

184. Six cases of HIV infection have occurred via donated frozen semen (four in Australia and two in Canada). See Supplement to Health and Welfare Canada, Federal Centre for AIDS, "Guidelines for Prevention of HIV Infection in Organ and Tissue Transplantation" (October 1989) 15S4 (Supp.) Canadian Diseases Weekly

Other transmissible diseases that should be screened for include hepatitis, cytomegalovirus, herpes, gonorrhea, chlamydia and mycoplasma. This is done by culture of the semen or through blood tests.[185] Careful screening of the donor with regard to lifestyle and medical and sexual history also reduces the risk of transmitting infectious diseases by rejection of high-risk donors.[186]

Ovum donors should be screened in the same manner as sperm donors even though it is not known whether the organisms in question can be transmitted by ova.[187] Since ovum freezing is not common,[188] the time span between donation and acceptance of the ovum by the recipient is limited. Therefore, prompt screening to the extent possible should be carried out to ensure the safety of the recipient and her potential pregnancy.[189] The risk of passing on genetic disease through ovum donation is the same as or even greater than with sperm donation, since there is the added risk of X-linked disorders. Thus, even under time restrictions, it is important that screening guidelines for genetic disease be followed in order that the recipient be fully informed and thus able to make decisions regarding the degree of potential risk.[190]

Report 1 at 2. A more recent report from New York City found that infected semen from six donors was used in 178 women and one women was recently found to be seropositive. On this issue see Mary Ann Chiasson, Rand L. Stoneburner and Stephen C. Joseph, "Human Immunodeficiency Virus Transmission through Artificial Insemination" (1990) 3 J. Acquired Immune Deficiency Syndrome 69. See also Canadian Fertility and Andrology Society, *supra*, note 11 at 3, which states that "there is no place for fresh semen in TDI [AID]. Semen cryopreservation must be used in conjunction with repeated AIDS screening of the donors so that only semen which has been quarantined for an absolute minimum period of 6 months (and, wherever possible 12 months) be used." See also Edwin P. Peterson, Nancy J. Alexander and Kamran S. Moghissi, "A.I.D. and AIDS: Too Close for Comfort" (1988) 49:2 Fertil. Steril. 209; Barratt, Chauhan and Cooke, *supra*, note 161.

185. Canadian Fertility and Andrology Society, *supra*, note 11 at 5.

186. *Ibid.*; and Ruth M. Greenblatt *et al.*, "Screening Therapeutic Insemination Donors for Sexually Transmitted Diseases: Overview and Recommendations" (1986) 46:3 Fertil. Steril. 351.

187. The American Fertility Society, The Ethics Committee, "Ethical Considerations of the New Reproductive Technologies" (1986) 46:3 (Supp. 1) Fertil. Steril.

188. See *supra*, note 175.

189. For an extensive discussion of screening, see Jalbert *et al.*, *supra*, note 151 at 269-75; and F. Clarke Fraser and R. Allan Forse, "On Genetic Screening of Donors for Artificial Insemination" (1981) 10 Am. J. Med. Genet. 399. Canadian Fertility and Andrology Society, *supra*, note 11 at 16; see also The American Fertility Society, *supra*, note 182.

190. The Canadian Council of Medical Geneticists is currently developing guidelines for genetic screening of ovum donors (Personal communication, Dr. F.C. Fraser).

Embryo donation carries with it the added (but necessary) burden of genetic screening of both parents. Ideally, the data should be kept in a registry in the event that an abnormality occurs at birth or a genetic disorder develops at a later time.[191] Surrogacy should require the same stringent screening procedures for sexually transmitted and genetic diseases.

To underscore the importance of all this, we might consider the following: the case of a surrogate who, unbeknownst to the contractual parents, was HIV positive. Subsequently, it was discovered that the newborn child was also seropositive. Both the contractual parents and the surrogate decided against keeping the child. Even though the contractual mother and the surrogate were sisters, the surrogate did not reveal that she was a drug addict and therefore at high risk for contracting the AIDS virus.[192] This illustrates that even in the case of known donors appropriate screening should be undertaken; most importantly, it demonstrates the consequences the child may have to bear in the absence of it.

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191. The literature suggests that in the case of gamete and embryo donation, record keeping (using codes to protect the anonymity of both donors and recipients) allowing the donor to be notified in the case of abnormality of the child may be important. One report suggests that notification is warranted when the condition is severe, carries a risk of recurrence (for future offspring) and is preventable. See Jalbert *et al.*, *supra*, note 151 at 272. It appears that appropriate notification of donors should be subject to further discussion.

192. Winston R. Frederick *et al.*, "HIV Testing of Surrogate Mothers" (1987) 317:21 New Engl. J. Med. 1351 (letter).

TABLE I: IVF International Results

Countries	Number of Hormone Cycles (HC)	Number of Couples Treated (CT)	Number of Embryo Transfers (ET)	Number of Clinical Pregnancies (CP)	CP/HC	CP/CT	Number of Miscarriages (M)	M/CP	Number of Ectopic Pregnancies (EP)	EP/CP	Number of Deliveries (D)	D/HC	Number of Live Births (LB)	LB/HC	Number of Multiple Births (MB)	MB/D
Canada																
1982–88	5 921	3 277	4 474	667	11.3%	20.4%	150	22.5%	47	7%	—	—	460	7.9%	—	—
United Kingdom																
1988	10 489	7 515	6 553	1 354	12.9%	18%	264	19.5%	69	5%	—	—	956	9%	—	24%
Australia and New Zealand																
1986	4 507	—	—	612	13.6%	—	159	26%	36	5.8%	417	9.3%	—	—	—	—
1979–1985	—	—	—	1 259	—	—	—	24.3%	65	5.2%	902	—	1 138	—	—	22.4%
United States																
1987	—	—	7 561	1 367	—	—	344	25%	103	7.5%	991	—	1 260	—	—	24%
1986	4 867	3 055	2 864	485	10%	16.9%	151	31.1%	22	4.5%	—	—	311	6.4%	—	—

Sources: Canada: Brown, *supra*, note 79 at 28, 31. **United Kingdom:** *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990*, *supra*, note 75 at 20-22. **Australia and New Zealand: 1986:** Stanley, *supra*, note 69 at 425; **1979-85:** Australian In-Vitro Fertilization Collaborative Group, *supra*, note 73 at 429-36. **United States: 1987:** Medical Research International and the Society of Assisted Reproductive Technology, *supra*, note 74 at 13-18; **1986:** Medical Research International and American Fertility Society Special Interest Group, *supra*, note 168 at 213-14.

TABLE II: GIFT International Results

Countries	Number of GIFT Procedures (GP)	Number of Clinical Pregnancies (CP)	CP/GP	Number of Miscarriages (M)	M/CP	Number of Ectopic Pregnancies (EP)	EP/CP	Number of Deliveries (D)	D/GP	Number of Live Births (LB)	Number of Multiple Births (MB)	MB/D
United Kingdom 1988	3 392	707	21%	—	—	—	—	—	—	—	139	20%
Australia 1986	607	136	22%	21	15%	7	5%	108	18%	—	—	—
United States 1987	1 968	492	25%	116	24%	30	6%	362	18%	489	103	28%

Sources: United Kingdom: *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990*, *supra*, note 75 at 20-22. **Australia:** Jones, Jr. and Rogers, *supra*, note 72 at 60. **United States:** Medical Research International and the Society of Assisted Reproductive Technology, *supra*, note 74 at 16.

TABLE III: Effects of the Number of Embryos Transferred on Pregnancy

Number of Embryos Transferred	Australia and New Zealand (1979–85)		United Kingdom (1988)		Canada (1984–87)	
	% of clinical pregnancies	% of multiple pregnancies	% of clinical pregnancies	% of multiple pregnancies	% of clinical pregnancies	% of multiple pregnancies
1	—	1	9.6	1	11	0
2	—	12	14.2	13.1	12	11
3	—	33	25.2	29.2	20	20
4	—	30	23.4	24.2	22	15
5	—	13	—	—	24	29

Sources: Canada: Yuzpe *et al.*, *supra*, note 65 at 169. **United Kingdom:** *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990*, *supra*, note 75 at 24. **Australia and New Zealand:** Paul A. L. Lancaster, "How Many Oocytes/Embryos Should Be Transferred?" (1987) II:8550 Lancet 109 at 110 (letter).

CHAPTER TWO

Issues in Canadian Law

By and large, Canadian law has not adapted easily to the various situations made possible by medically assisted procreation. We will therefore outline in this second chapter the main problems these technologies create for the law. The scope of the task is clearly illustrated by the number of branches of the law and the range of legislation, both federal and provincial, that must be considered. The legal framework within which medically assisted procreation is developing is in fact very broad. It covers such diverse concepts, principles and branches of the law as public policy, parentage, the principle of the non-availability of the human body for commercial purposes,[193] the right to life, the right to liberty, property law, contract law and tort law. In order to identify the legal problems, we will first examine the main rules of law applicable to medically assisted procreation.

I. Medically Assisted Procreation and Private Law

As we will see, a number of rules of private law affect medically assisted procreation. We will look at the rules that govern consent, parentage, successions, contracts, property and liability and their impact on the use of artificial insemination, in vitro fertilization, gamete intrafallopian tube transfer (GIFT) and egg retrieval by uterine lavage. We will consider these rules from the perspective of potential parents, donors, children and medical personnel, because they are the most affected by the legal problems that can arise when medically assisted procreation technologies are used.

A. Potential Parents

1. Consent

The decision to have a child is a private one, normally made within a marriage by both partners. However, medically assisted procreation makes it possible for a woman to conceive a child without her spouse's knowledge; this raises the problem of attributing

193. See *infra* at 41ff.

paternity to a man who is not genetically linked to the child and did not consent to conception.[194] Irrespective of the remedies available to the spouse (separation, divorce, disavowal of paternity),[195] we may consider the need for specific legislative intervention in this area. Should the law make the consent of both spouses a prerequisite for medically assisted procreation?

The problem with such intervention is obvious. Giving a husband the power to decide whether a child should be conceived in effect violates the wife's right to control her own body and her reproductive autonomy.[196]

Currently only Quebec, the Yukon Territory and Newfoundland have provisions dealing with consent to medically assisted procreation, although there is no specific indication of the form of such consent. Article 586 of the *Civil Code of Québec* (*C.C.Q.*) reads as follows:

> When a child has been conceived through artificial insemination, either by the father or, with the *consent* of the spouses, by a third person, no action for disavowal or contestation of paternity is admissible [emphasis added].[197]

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194. We are referring here to cases where gametes from a third person are used, since the spouse's sperm cannot be used without his consent.

195. Michèle Rivet, "Quand la médecine intervient dans la genèse de la conception, que fait le droit? Ou le délicat problème de l'insémination artificielle" in Association Henri Capitant, *Le corps humain et le droit: Journées Belges*, vol. 26 (Paris: Dalloz, 1977) 87 at 95, [Translation] "Artificial insemination, whether AID or AIH, without the husband's consent does not constitute adultery but is a violation of matrimony that in itself warrants sanction."; Jean-Louis Baudouin, "Aspects juridiques" in Marcel J. Melançon, ed., *L'insémination artificielle thérapeutique* (Quebec: P.U.L., 1983) 113 at 121,

> [Translation]
> [I]n all systems of law, spouses accept, through the bond of marriage, the obligation to help, assist and be faithful to one another. It is perfectly logical, therefore, to say that AID without the husband's knowledge may be considered a failure to meet that obligation and may become general grounds for divorce or separation as "outrage, ill-usage or grievous insult," "mental cruelty" or "irretrievable damage to the will to maintain the bond of marriage."

196. Requiring the husband's consent is viewed by some as contradicting health legislation. See Bartha Maria Knoppers, *Conception artificielle et responsabilité médicale* (Cowansville, Que.: Yvon Blais, 1986) at 96; in the area of consent to medical treatment or access to medical services, respect for the person's autonomy prevails. Consequently, if one spouse is able to express his or her own wishes, the consent of the other cannot be required before treatment is administered. See also Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 2d ed. (Toronto: Carswell, 1984) at 62-63. In Quebec, *An Act respecting health services and social services*, R.S.Q., c. S-5, s. 156, states that: "The consent of the consort shall not be required for the furnishing of services in an establishment." See also arts 19, 19.1 to 19.4 of the *Civil Code of Lower Canada (C.C.L.C.)* and art. 10ff. of Bill 125, *Civil Code of Québec*, 1st Sess., 34th Leg., Quebec, 1990 (1st Reading, 18 December 1990) [hereinafter Bill 125]. In Ontario, see the *Family Law Act, 1986*, S.O. 1986, c. 4, s. 64(2): "A married person has and shall be accorded legal capacity for all purposes and in all respects as if he or she were an unmarried person."

197. Article 580 of Bill 125, *supra*, note 196, reiterates these principles:

> No person may contest the filiation of a child on grounds relating to his medically assisted procreation, and no claim to another status is admissible from the child.
>
> However, the husband of the mother may disavow the child or contest acknowledgement if he did not give consent to medically assisted procreation or if he proves that the child was not born of such procreation.

For the Yukon, see *Children's Act*, R.S.Y.T. 1986, c. 22, s. 13(3)-(5). Subsection 13(3) states: "A man who is married to a woman at the time she is artificially inseminated solely with the semen of another man shall be deemed in law to be the father of the resulting child if he consents in advance to the insemination." For Newfoundland, see *The Children's Law Act*, S.N. 1988, c. 61, s. 12(3).

Some view this provision as requiring the husband's consent. On closer inspection, however, consent here is merely a defence in bar against any action in disavowal of paternity in cases involving parentage, divorce or successions.[198] Therefore, the effect of the provision is not to recognize the husband's authority to decide, but rather to attach consequences to his consent[199] by preventing him from alleging the absence of a biological link to disown a child whose conception he desired. We will come back to this point.

The fact that there are remedies available to the husband[200] and the importance of the woman's right to control her own body and her reproductive autonomy lead the Commission to conclude that the husband's consent should not be required for medically assisted procreation.

It should be noted that the question of consent by both future parents can be considered from another perspective, namely that of the appropriateness of ensuring legal protection of the traditional family unit in which there are two heterosexual parents. Requiring the consent of both future parents would prevent single people and homosexual couples from using medically assisted procreation. Clearly, such intervention would raise important constitutional issues and would have to reflect a societal choice between several fundamental values. It is this fundamental aspect of the question of access to medically assisted procreation that we will examine in detail later.

2. Control over Gametes and Embryos

Infertile individuals or couples who entrust a bank with their gametes or embryos normally intend to retain exclusive control over the way they are used.[201] However, the basis of such control must be examined in terms of the law. Could it be a right of ownership, a right of possession or a contractual relationship (respect for the consent and intentions

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198. The Yukon and the Newfoundland provisions are found in the section entitled "Establishment of Parentage."

199. A similar approach is used in s. 11.2 of *An Act to amend the Uniform Child Status Act*, passed in August 1991, amending the *Uniform Child Status Act* (1980), Uniform Law Conference of Canada, *Consolidation of Uniform Acts* (Fredericton, N.B.: The Conference) Permanent Codification at 5-1:

> 11.2. Notwithstanding section 6(3), for a child born before or after this section comes into force as a result of an assisted conception, a presumption of paternity pursuant to section 9 may be rebutted only by proof that
>
> (a) the presumed father
> (i) is not the genetic father of the child, and
> (ii) did not consent, or before conception withdrew his consent, to be the father of any child born as a result of the assisted conception; or
>
> (b) where the sperm of the presumed father was used in the assisted conception,
> (i) he did not consent, or before conception withdrew his consent, to be the father of any child born as a result of the assisted conception, and
> (ii) the child was not conceived as a result of sexual intercourse between the mother and him.

200. See *supra* at 38.

201. We will examine the donor's situation in the following section. See *infra* at 46ff.

of the producer of the gametes)? Three decisions, one in France in 1984,[202] the other two in the United States in 1988 and 1989 — *Davis*[203] and *York*,[204] — ruled on such matters. We will turn our attention first to gamete storing in light of the French ruling, and then to the fate of embryos in light of the U.S. rulings.

On the subject of gamete storing, a French court was asked to rule in 1984 in the *Parpalaix*[205] case, which involved a dispute between CÉCOS, a centre for sperm analysis and storage, and the widow of a man who had stored sperm at the centre. The centre refused to grant the widow's request to retrieve the sperm so that she could be artificially inseminated. The widow argued that her husband and the centre had signed a contract of deposit.

The judge ruled that in the case in question the agreement was not a contract of deposit but rather an innominate contract under which CÉCOS agreed to store the sperm and return it on request to the producer or, following his death, his heirs. The judge wrote:

> [TRANSLATION]
> The rules of the contract of deposit as defined by article 1915 *et seq.* C.C. cannot be applied in the case at bar, which concerns not *objects of commerce*, but rather a secretion that contains the seed of life and is to be used to produce a human being. . . .
>
> It appears that the agreement of 7 December 1981 was a specific contract under which CÉCOS was obligated to store the sperm and return it to the donor or the woman for whom the sperm was intended [emphasis added].[206]

The court did not go so far, however, as to determine that the husband owned the gametes. Rather, it ordered that the sperm be returned on the basis of the deceased man's intentions and the absence of a stipulation that CÉCOS intended to keep the sperm if the producer died.

The reference by the judge in the case to things that are not objects of commerce needs clarification. In the civil law, things that are not objects of commerce are not subject

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202. Trib. gr. inst. Créteil, 1 August 1984, *Parpalaix* v. *C.É.C.O.S.*, Gaz. Pal. 1984.II.560.

203. *Davis* v. *Davis* (21 September 1989), Blount Cty E-14496 (Cir. Ct) at 1-2; this decision has since been reversed by 59 U.S.L.W. 2205 (Tenn. App. 1990). See *infra*, note 216 for more details.

204. *York* v. *Jones Institute*, 717 F. Supp. 421 (E.D. Va 1989) (order of 10 July 1989 denying defendants' motion to dismiss). See *infra*, note 217, for more details. Note that the United States and Australia have also had to consider this issue in the *Rios* case; *In re Estates of Elsa and Mario Rios* (May 1985), Los Angeles Cty P680682, P680683 (Sup. Ct). The California Superior Court decided not to appoint a guardian for the embryos and ruled that they were neither the heirs nor the property of the Rioses. See George P. Smith, "Australia's Frozen 'Orphan' Embryos: A Medical, Legal and Ethical Dilemma" (1985) 24 J. Fam. L. 27. See also Tamara L. Davis, "Protecting the Cryopreserved Embryo" (1990) 57 Tenn. L. Rev. 507 at 518.

205. *Supra*, note 202. For an interesting analysis of this ruling, see Jones, *supra*, note 147.

206. *Parpalaix*, *supra*, note 202 at 562.

to human will and cannot be disposed of, even gratuitously.[207] The word "commerce," therefore, has a very specific meaning here,

> [TRANSLATION]
> a special meaning more general than its usual one. It refers not only to commercial transactions *per se* . . . but to any legal act the purpose of which is to create, modify or extinguish rights. A thing that is not an object of commerce is a thing that cannot be the object of legal acts performed by individuals. "Commerce" evokes the notion of things circulating among persons, but it is not synonymous with the economic term "market."[208]

This broad definition explains in part why some French authors are sceptical about including the body and its parts and substances among things that are not objects of commerce.[209]

In any event, in Quebec civil law article 20 *C.C.L.C.* permits the *inter vivos* disposal of parts or products of the body,[210] even in return for payment. It may therefore be concluded that, to the extent that article 20 applies to sperm and ova, gametes could be objects of commerce in Quebec civil law.[211]

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207. Marie-Angèle Hermitte, "Le corps hors du commerce, hors du marché" (1988) 33 Arch. philo. dr. 323 at 325.

208. Jean-Christophe Galloux, "Réflexions sur la catégorie des choses hors du commerce: l'exemple des éléments et des produits du corps humain en droit français" (1989) 30:4 C. de D. 1011 at 1015-16.

209. Hermitte, *supra*, note 207 at 327, holds the view that the body itself is an object of commerce. Commenting on s. 1128 of the French Civil Code (equivalent to art. 1059 *C.C.L.C.*), she writes:

> [TRANSLATION]
> It is therefore not the body that is protected in this way, placed beyond the exercise of will by article 1128, but rather the *person*, a legal abstraction defined by attributes, themselves abstract, that are considered to be the framework of human dignity. . . . This illustrates by *reductio as absurdum* that the civil law views the body as nothing more than an incidental medium for representations that centre on the person, defined by changing references to morals, dignity and liberty. Violations of the body are not taken into consideration until they engender a violation of these values.

See also Galloux, *supra*, note 208 at 1019, on the limited scope in French law of the notion of "extracommerciality" as it relates to the products and elements of the human body. Citing as examples blood, mother's milk and gametes, he concludes that [TRANSLATION] "[h]uman products circulate among private or public individuals; they do not, as the status of extracommerciality would require, remain under the exclusive control of the person from whom they come."

210. Jean-Louis Baudouin and Catherine Labrusse-Riou, *Produire l'homme: De quel droit?* (Paris: P.U.F., 1987) at 44: [TRANSLATION] "In Quebec law, the provisions so adopted apply not only to organs themselves, but also body substances (blood, sperm, etc.)." See also arts 19 and 24 of Bill 125, *supra*, note 196. However, art. 25 of the bill drops the distinction between parts of the body that are capable of regeneration and those that are not by requiring that alienation be gratuitous in all cases. Art. 25 reads: "The alienation by a person of a part or product of his body shall be gratuitous; it shall not be repeated if it involves a risk to his health."

211. Baudouin and Labrusse-Riou, *supra*, note 210 at 115: [TRANSLATION] "However, such liberalization is possible only from a therapeutic perspective or at least one of scientific experimentation leading to the development of a treatment."

It follows therefore that article 1059 *C.C.L.C.*, which states that "[t]hose things only which are objects of commerce can become the object of an obligation,"[212] could not impede the creation of rights and obligations between the bank and persons who deposit their gametes.[213] Gametes could thus be the subject-matter of a contract. It should be noted, however, that such freedom of contract would be subject to the criterion set out in article 20(1) (proportionality of risks[214]) and to articles 13 and 990 *C.C.L.C.* (public order and good morals).[215]

The agreement between the bank and the person storing his or her gametes could therefore be used to create rights and obligations for the parties. With respect to the couple, it would be sufficient for each partner to enter into a separate contractual relationship with the bank to have independent control over his or her gametes. This would prevent disputes over the use of one partner's gametes if, for any reason, he or she no longer wished to proceed with the parental plan. However, an additional problem arises with ova. Since freezing of ova seems to pose major difficulties, the normal procedure is to freeze eggs that have been fertilized in vitro (embryos). Once the egg has been fertilized, independent control of the gametes must give way to a form of joint control.

Whether the embryo is produced by the couple or from one or two donated gametes, the question of control is a delicate problem. In case of separation, for example, both spouses may claim the embryos, or one spouse may object to their being used. We must therefore provide for how such disputes can be resolved where no provision has been made in the contract or the consent form signed by the spouses. The U.S. decisions in *Davis* v. *Davis*[216]

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212. See also art. 1058 *C.C.L.C.*

213. In the event of a conflict, the specific prevails over the general provision: Pierre-André Côté, *The Interpretation of Legislation in Canada* (Cowansville, Que: Yvon Blais, 1984) at 240.

214. The risk assumed must not be disproportionate to the benefit anticipated. See art. 20 *C.C.L.C.*, *infra* at 47.

215. Albert Mayrand, *L'inviolabilité de la personne humaine* (Montreal: Wilson & Lafleur, 1975) at 81.

216. *Supra*, note 203. The case centred on the absence of a consent form or document providing for the disposition of the embryos in the event that Mr. and Mrs. Davis divorced. Despite the divorce, Mrs. Davis wanted to use the frozen embryos in the hope of having a child, but Mr. Davis objected on the grounds that he had no intention of becoming a father. Mrs. Davis claimed that the embryos were living and that as a mother she was entitled to use them to try to conceive. She argued that if she were unable to use them herself, the embryos should be given to an infertile couple so that they could be carried to term. The trial judge, W. Dale Young, ruled as follows (*supra*, note 203 at 1-2):

and *York* v. *Jones Institute*[217] bear witness to the problems that can arise and the difficulty in resolving them.

It is to be hoped that the experience gained from these cases will result in more suitable consent forms. In any case, is it possible to make provision in a consent form for the fate of an embryo in the event of a dispute, separation, divorce or death?[218] This leads us

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> The salient findings, conclusions and the judgment are summarized as follows, to-wit: (1) Mr. and Mrs. Davis undertook *in vitro* procedures for the purpose of producing a human being to be their child. (2) The seven cryogenically preserved embryos are human embryos. ... (5) From fertilization, the cells of a human embryo are differentiated, unique and specialized to the highest degree of distinction. (6) Human embryos are not property. (7) Human life begins at conception. (8) Mr. and Mrs. Davis have produced human beings, *in vitro*, to be known as their child or children. (9) For domestic relations purposes, no public policy prevents the continuing development of the common law as it applies to the seven human beings existing as embryos, *in vitro*, in this domestic relations case. (10) The common law doctrine of *parens patriae* controls children, *in vitro*. (11) It is to the manifest best interests of the child or children, *in vitro*, for their Mother, Mrs. Davis, to be permitted the opportunity to bring them to term through implantation.
>
> ...
>
> The temporary custody of the seven cryopreserved human embryos is vested in Mrs. Davis for the purpose of implantation. All issues of support, visitation, final custody and related issues are reserved to the Court for consideration and disposition at such time as one or more of the seven human embryos are the product of live birth.

For more details about this case, see John A. Robertson, "Resolving Disputes over Frozen Embryos" (1989) 19:6 Hast. Cent. Rep. 7 at 11.

> Judge Young's conclusion that four-celled preimplantation human embryos are "children" and "human beings" is unprecedented and unwarranted. It has no discernible basis in common law precedents nor in Tennessee law (which recognizes a separate legal interest in prenatal human life only at viability). It is a view rejected by highly respected ethical advisory bodies in the United States, Great Britain, Canada, France, and several other countries. This remarkable conclusion appears to represent the judge's own personal view of the significance of the biological fact that a new human genome exists at or shortly after fertilization.

On appeal from the *Davis* decision (*supra*, note 203 at 2206), the judge ruled:

> The trial court in his fact finding and legal conclusions, ignored the public policy implicit in the Tennessee Statutes, the cases holdings of the Tennessee Supreme Court and the teachings of the United States Supreme Court. We are required to resolve the issue consistent with the existing Tennessee law and the parties' constitutional rights. On the facts of this case, it would be repugnant and offensive to the constitutional principles to order Mary Sue to implant these fertilized ova against her will. It would be equally repugnant to order Junior to bear the psychological, if not the legal consequences of paternity against his will. Jointly, the parties share an interest in the seven fertilized ova.
>
> Accordingly, the cause is remanded to the trial court to enter a judgment vesting Mary Sue and Junior with joint control of the fertilized ova with equal voice over the disposition.

217. *Supra*, note 204. The issue in this case was a couple's right to transfer a frozen embryo from one fertility clinic to another. The consent form signed by Mr. and Mrs. York did not provide for the possibility of a change in physicians.

218. Bernard M. Dickens, "Artificial Reproduction and Child Custody" (1987) 66 Can. Bar Rev. 49 at 65: "A contract could be directed to the rendering of scientific or medical services, including maintenance of an embryo *in vitro* or in cryopreservation, and need not involve concepts of property law."

to question the status of the embryo: Does it fall under the law of property or that of persons? Positive law is unable to answer this question, which is a philosophical, theological and ethical problem: At what point does human life begin?[219]

The question of control over gametes and embryos has been considered from the perspective of property law:

> The elements of use, alienation . . . , disposal and destruction, even when exercised subject to statutory regulation, appear to comprise the power legally contained in the concept of property ownership. According to property principles, it seems that the gamete donors could exercise control over the embryo *extra uterum*, abandon their respective rights of control to the exclusive exercise of the other (as in ordinary artificial insemination by sperm donor), agree upon its transplantation into another woman without invoking adoption law, and rely on property principles in settling disagreements on disposition. In the same way, gamete donors may delegate to clinics and clinic personnel their own authority to decide, for instance, which women may receive transplantations of spare embryos.[220]

However, the nature of the "deposited" product makes such an a approach difficult.[221] Some hold the view that this property right is inconsistent with the traditional

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219. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 46-47. See also the recent decisions in *Murphy* v. *Dodd* (1989), 70 O.R. (2d) 681 (H.C.J.); *Tremblay* v. *Daigle* (7 July 1989), Abitibi 170-05-000012-898 (Québec Sup. Ct)(interim interlocutory injunction); [1989] R.J.Q. 1980 (Sup. Ct) (interlocutory injunction), appeal dismissed [1989] R.J.Q. 1735 (C.A.), reversed by unanimous decision of the Supreme Court of Canada, [1989] 2 S.C.R. 530. It should be noted, however, that an embryo fertilized in vitro is not covered by the definition of fetus in the working paper *Crimes against the Foetus*, *supra*, note 7 at 50: "the product of a union in the womb of human sperm cells and egg cells at all stages of its life prior to becoming a person."

220. Dickens, *supra*, note 218 at 62-63. And at 64-65: "Destruction or other misappropriation of an object without the owner's consent may constitute the crime of theft, and/or the torts of trespass to property and conversion."

221. Bartha M. Knoppers, "Reproductive Technology and International Mechanisms of Protection of the Human Person" (1987) 32 McGill L. J. 336 at 346:

> [A]ll agree that the embryo *in vitro* constitutes human life worthy of protection . . . while the majority deny the possibility of granting the donor a proprietary interest in human gametes or embryos, most would seem to grant the donor at least some possessory interest, and in some cases, a residual right. . . . Indeed, there is no area where the need for some common international principles of respect and protection is more imperative, if we are truly to distinguish between human genetic material as property, as a simple product of conception or as human life.

Bernard M. Dickens, "The Ectogenetic Human Being: A Problem Child of Our Time" (1980) 18 U.W.O. L. Rev. 241 at 245, "Litigation in the United States arising from hospitals losing or incinerating fetuses their mothers wanted to bury has been framed in terms of causing emotional injury rather than of misappropriating property." The author refers to *Brooks* v. *South Broward Hospital District*, 325 So. 2d 479 (Fla App. 1975) and *Hembree* v. *Hospital Board of Morgan County*, 300 So. 2d 823 (1974). In *Del Zio* v. *Manhattan's Columbia Presbyterian Medical Center* (14 November 1978) 74-3558 (D.S.N.Y.), when a fertilized egg was destroyed, a U.S. Federal Court judge allowed a claim for damages for loss of property to be heard by a jury. However, "[t]he jury rejected the property claim but awarded plaintiffs damages for the emotional distress. Mrs. Del Zio was awarded $50,000 for emotional distress and Mr. Del Zio was awarded $3.00." Lori B. Andrews, "My Body, My Property" (1986) 16:5 Hast. Cent. Rep. 28 at 29ff.

legal interpretation of the concept and that it is rather a right of supervision and control.[222]

In view of this clear gap in the law, several options are possible. One would be to leave it to the courts to adapt current principles of law to gametes and embryos in order to address the problems they create. Alternatively, we could rethink the traditional legal distictions between persons and things in order to deal specifically with these products of the human body.[223] Finally, it might also be appropriate to look into the possibility of adapting, with respect to these substances, the notion of things that are not objects of commerce.[224] This dilemma is not limited to the problem of control over these substances; it also applies to the very legitimacy of donating gametes and embryos and to their commercialization. These issues will be discussed later.

3. Post-Mortem Use of Gametes and Embryos

The issue of the post-mortem use of gametes and embryos brings us back to the question of the right to dispose of them and of their legal status.[225] Does a widow or widower have any rights over the gametes of his or her deceased spouse or any frozen embryos that they have conceived together?

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222. According to Baudouin and Labrusse-Riou, *supra*, note 210 at 45-46,

> [TRANSLATION]
> the donor must be recognized as having not a true property right, but more a right of supervision and control over the use of his or her gametes, a matter which is part of the broader issue of personality rights. For obvious social reasons, however, the donor must not be permitted to exercise this right in the same way as a true property right. A balance must therefore be struck *de lege ferenda* between respect for the consent and intentions of the donor on the one hand and on the other the exercise of this right in a manner that is compatible with the ethical and social requirements of society as a whole.

The term "donor" seems to be used here to designate both a person who makes a deposit and a person who makes an actual donation, that is, who relinquishes the product donated; *ibid.*, [TRANSLATION] "It is difficult to imagine, for example, a *donor* bequeathing a large fortune to his granddaughter on the condition that she be inseminated after his death with the sperm he *deposited* in a bank for this purpose!" [emphasis added]. The Ontario Law Reform Commission writes:

> It was suggested that the fact that a person does not have absolute beneficial ownership of an object does not mean that he or she has no property or other (for example, possessory) interest in it. [Note 224: For example, under certain circumstances, the *Anatomy Act*, R.S.O. 1980, c. 21, permits the possession of corpses by medical schools for dissection and medical education, even though it has been said that a dead body cannot be the subject of a property right.] Accordingly, even if there are some restrictions on a woman's rights respecting her own ova, presumably some type of interest may still be found in her. And, of course, one person's right or interest in genetic material, however that right or interest is characterized, may permit that person to, for example, donate it to a hospital for experimental purposes, or require it to be destroyed notwithstanding the claims of others to use it for such purposes: that right or interest may well be superior to that of anyone else. [OLRC, *supra*, note 2 at 88].

223. See Hermitte, *supra*, note 207.

224. See Galloux, *supra*, note 208.

225. See *supra* at 39 and 43.

As we have seen in the *Parpalaix* case,[226] the French courts have held the storing of sperm to be a specific contract and ordered the sperm to be returned to the widow of the donor, thereby permitting post-mortem insemination. This conclusion, however, could only be reached through a very legalistic interpretation of the dispute, since the judge did not rule specifically on the use of the sperm for post-mortem insemination.

On a more practical level, it is easy to anticipate the serious problems that post-mortem use of gametes and embryos will create in parentage law and the law of successions.[227] In Canada, neither the law of successions nor parentage law recognizes post-mortem procreation. Presumptions of paternity normally use a test of 300 days between the death of the father and the birth of the child.[228] In Ontario, if no one is presumed to be the father under the 300-day test, any person may apply for a declaration of paternity,[229] provided that "both the persons whose relationship is sought to be established are living."[230]

We may therefore question the appropriateness of making provision in Canadian law for the impact of the post-mortem conception of a child on parentage and inheritance rights. But we must first decide if we wish to allow or prohibit the post-mortem use of gametes and embryos in Canadian society.

B. Donors

1. The Legality, Legitimacy and Nature of Gamete and Embryo Donation[231]

The legality of such a donation is linked to the principle of the inviolability of the human body.[232]

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226. *Supra*, note 202.

227. For example, see the *Rios* case, *supra*, note 204.

228. For example, see *Children's Law Reform Act*, R.S.O. 1980, c. 68, s. 8(1) 2nd para., which presumes paternity if "[t]he person was married to the mother of the child by a marriage that was terminated by death ... within 300 days before the birth of the child." In Quebec, art. 574 *C.C.Q.* states that a child born more than 300 days after the death of the biological father is deemed to have been conceived after the father's death; see also art. 523 of Bill 125, *supra*, note 196.

229. See *Children's Law Reform Act*, *supra*, note 228, s. 5(1).

230. *Ibid.*, s. 5(2). Dickens, *supra*, note 221 at 247, "This would bar, of course, both the dead biological father and the unborn child, and appear to leave the fetus not that of the father for the purposes of the perpetuity rule or other property interests." It should be noted, however, that the *Uniform Child Status Act* (*supra*, note 199) provides for an exception to this rule where a presumption of paternity pursuant to s. 9 applies. The presumption of paternity provided for in the event of the death of the child's father indicates no time limit regarding the birth of the child or the death of the husband. See ss 6(6) and 9(a).

231. Legality is used here to mean the compliance of an action or undertaking with the law, while legitimacy refers to the ethical and social criteria that make it desirable to prohibit, allow or simply tolerate such an action or undertaking.

232. In Quebec this principle is established by art. 19 *C.C.L.C.*: "The human person is inviolable. No one may cause harm to the person of another without his consent or without being authorized by law to do so." See also arts 19.1-19.4 *C.C.L.C.* and art. 10ff. of Bill 125, *supra*, note 196.

> Inviolability . . . may have two contents of meaning. It may connote that one is not justified in treating another without his consent, but is justified in doing so with it, in which case it is merely a particular application of the autonomy principle; or it may indicate a principle that protects a person's physical and mental integrity against non-beneficial acts by the person himself, or others, when it is a preservation of life value.[233]

This second interpretation of the principle of the inviolability of the human body imposes a limit on what a person can consent to. It is this second aspect that seems to have captured the Quebec legislature's interest when the *Civil Code of Lower Canada* was amended in 1971.[234]

Article 20 *C.C.L.C.* allows competent persons to dispose of parts of their bodies, whether or not the body part is capable of regeneration, subject in both instances to article 19.1 (proportionality of risks) and written consent. Article 20 reads as follows:

> A person of full age may consent in writing to disposal *inter vivos* of a part of his body or submit to an experiment provided that the risk assumed is not disproportionate to the benefit anticipated.
>
> A minor capable of discernment may do likewise with the authorization of a judge of the Superior Court and with the consent of the person having parental authority, provided that no serious risk to his health results therefrom.
>
> The alienation must be gratuitous unless its object is a part of the body susceptible of regeneration.
>
> The consent must be in writing; it may be revoked in the same way.

To the extent that the conditions set out in article 20 are met and gametes are considered parts of the body within the meaning of the article, there is no doubt in Quebec law as to the legality of gamete donation.[235]

In the common law provinces, tissue donation is covered by statutes based on the *Uniform Human Tissue Gift Act*,[236] subsection 3(1) of which reads as follows:

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233. Margaret A. Somerville, *Consent to Medical Care*, study paper prepared for the LRC (Ottawa: Supply and Services Canada, 1980) at 5.

234. See François Heleine, "Le dogme de l'intangibilité du corps humain et ses atteintes normalisées dans le droit des obligations du Québec contemporain" (1976) 36 R. du B. 2 at 10.

235. See Baudouin and Labrusse-Riou, *supra*, note 210 at 44. It should be noted that arts 18-22 of *An Act to add the reformed law of persons, successions and property to the Civil Code of Québec*, S.Q. 1987, c. 18, essentially reiterate art. 20ff. *C.C.L.C.* and add specific requirements and conditions. See Monique Ouellette, "De la jouissance et de l'existence des droits civils et de certains droits de la personnalité" (1988) 1 C.P. du N. 1 at 20. See also arts 19-25 of Bill 125, *supra*, note 196.

236. *Uniform Human Tissue Gift Act*, repealed and replaced by *Uniform Human Tissue Donation Act* (1989), Uniform Law Conference of Canada, *supra*, note 199 at 22-1.

> Any person who has attained the age of majority, is mentally competent to consent, and is able to make a free and informed decision may in a writing signed by him consent to the removal forthwith from his body of the tissue specified in the consent and its implantation in the body of another living person.[237]

Although the *Uniform Human Tissue Gift Act* (UHTGA) does not state that the risk incurred is not to be disproportionate to the anticipated benefit, the common law recognizes this condition.[238] However, unlike the *Civil Code*, the UHTGA excludes tissue capable of regeneration.[239]

Thus, insofar as sperm and even eggs (despite the fact that eggs are limited in number) are parts of the body capable of regeneration,[240] statutory provisions on human tissue

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The Canadian statutes on tissue donation are: *Human Tissue Gift Act*, R.S.A. 1980, c. H-12; *Human Tissue Gift Act*, R.S.B.C. 1979, c. 187; *The Human Tissue Act*, S.M. 1987-88, c. 39; *The Human Tissue Act, 1971*, S.N. 1971, No. 66; *Human Tissue Act*, R.S.N.B. 1973, c. H-12; *Human Tissue Gift Act*, R.S.N.S. 1989, c. 215; *Human Tissue Gift Act*, R.S.O. 1980, c. 210; *Human Tissue Gift Act*, R.S.P.E.I. 1988, c. H-13; *The Human Tissue Gift Act*, R.S.S. 1978, c. H-15; *Human Tissue Act*, R.S.N.W.T. 1988, c. H-6; *Human Tissue Gift Act*, R.S.Y.T. 1986, c. 89; see in particular, for example, the Ontario statute, s. 1(c), and the Alberta statute, s. 1(b).

237. *Supra*, note 236, s. 1(c) defines "tissue" as follows: "'tissue' includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair."

238. See Knoppers, *supra*, note 196 at 95-96 n. 149. See also Bernard M. Dickens, "The Control of Living Body Materials" (1977) 27 U.T.L.J. 142 at 165: "The dividing line between permissible and prohibited tissue loss remains a matter of public policy, as judicially determined, but public policy evolves over the course of time, and can be adapted to accommodate biotechnical developments and changing social priorities and recognition of the limits of self-sacrifice." See also, generally, Picard, *supra*, note 196 at 67ff. and at 125ff.; *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192; *Reibl* v. *Hughes* (1977), 16 O.R. (2d) 306 (H.C.J.), rev'd (1978) 21 O.R. (2d) 14 (C.A.), rev'd by [1980] 2 S.C.R. 880. Further, in criminal law, s. 45 of the *Criminal Code*, R.S.C. 1985, c. C-46, provides:

> Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if
> (*a*) the operation is performed with reasonable care and skill; and
> (*b*) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all circumstances of the case.

See also s. 14 of the *Criminal Code*.

239. *Supra*, note 236. The latest version of the statute, *Uniform Human Tissue Donation Act*, *supra*, note 236, available for adoption by the provinces, provides in s. 1 that "'tissue' means a part of a living or dead human body, but does not include (a) spermatozoa or ova, (b) an embryo or fetus." It remains to be seen whether the provinces will adopt these amendments.

240. See Knoppers, *supra*, note 196 at 109; Heleine, *supra*, note 234 at 61: [TRANSLATION] "[I]n medicine as we know it today, blood, milk, hair, skin, bone marrow and genetic material are considered parts of the body susceptible of regeneration." Commenting on the Ontario statute (*supra*, note 236), the OLRC wrote in its report, *supra*, note 2 at 60:

donation do not apply, and the donation of gametes is governed by the common law: "Under the common law, an adult, if fully informed, can consent to having regenerative tissue removed from his body. Indeed, the Red Cross Blood Transfusion Service is wholly dependent on such donations."[241]

While we may conclude (subject to the ambiguity surrounding the characterization of gametes) that our systems of law seem to cast aside any doubt as to the legality of gamete donations, the legitimacy of such donations is certain to draw comment because of the very nature of gametes.

For some authors, discussions of gamete and embryo donation are too often centred on the controls and conditions that may be imposed, thereby clouding the question of the ethical value of such donations:

> [Translation]
> Some essential questions concerning the donation of gametes have thus been purely and simply "medicalized" and therefore trivialized. Science has taught us to think that the problems lie not in the ethical value of the actual procedure, but rather, because the procedure is established, in the controls and conditions which may be imposed. Accordingly, the public and jurists have been conditioned to believe that the legitimacy and, consequently, the legality of gamete donation were no longer open to discussion in ethical and legal terms. All that remained was to look to the law for procedural management models. In focusing the debate on the question of "how," we truly lost sight of "why." Science has acted as if the only real problems were technical.[242]

Some hold the view that the question of the legitimacy of gamete donation cannot be settled until an ethical and legal analysis has been conducted of the fundamental issues gamete donation raises for our society. Marie-Angèle Hermitte summarized the question as follows:

> [Translation]
> We have to decide whether or not we want to be a society that considers kinship to be subject to commercial transactions. ... To answer the question, we need to determine whether the "transaction" is to be analysed as simply a donation of life or as a shift in the order of consanguinity. The analysis in the first case is materialistic and purely biological: AID is viewed as a somewhat magical treatment for sterility. In the second case, the donation

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> The critical question is, of course, whether the Act applies to the donation of sperm or ova, or, put another way, whether sperm or ova come within the definition of "tissue" in the Act. Section 1(c) provides that "tissue" includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair.
> ...
> There would appear to be little controversy that sperm comes within the closing flush of section 1(c) and, accordingly, is outside the purview of section 3(1). However, the same may not be said of ova. A woman's complement of ova is fixed and not replaceable; she loses one or more during menstruation from puberty to menopause.

241. Picard, *supra*, note 196 at 129. See also Dickens, *supra*, note 238 at 163-64.

242. Baudouin and Labrusse-Riou, *supra*, note 210 at 195.

> of life is part of the logic of genealogy, and one realizes that a branch of the family tree is being broken. In the end, the questions remain the same: Are bodies nothing more than living matter which may be passed on according to the rules of trade? Are they not also the medium for the cultural representations that transcend them, at least in part?[243]

Having briefly analysed the question of gamete donation, we must now turn our attention to embryo donation. Neither the civil nor the common law provides for the donation of embryos. Indeed, it may be difficult to consider embryos as tissues or parts of the body (whether capable of regeneration or not). The ambiguity of the embryo's status gives rise to moral and social objections that have appeared with the creation and freezing of surplus embryos. What is at issue here is one's image of the embryo: Is it a thing, a person, a potential person, or something else? The question of the legitimacy of embryo donation therefore remains completely unanswered. Do we wish to legalize or prohibit embryo donation?

To end this discussion of the legality and legitimacy of gamete and embryo donation, we might ask ourselves in more general terms whether we wish to treat gametes and/or embryos differently from other parts of the body or alienable cells, or in other words, create a special regime suited to the specific nature of gametes and embryos.[244]

In concluding, we should address the question of the very nature of gamete and embryo donation. Are such donations blind or conditional? In other words, are donors entitled to attach conditions to the donation? May they withdraw their consent?

While the donation of tissues and body substances such as blood, milk and bone marrow creates few moral problems, the donation of gametes and embryos, which entails the potential to create a human life, is more problematic. In light of the significance of such donations, the donor may wish to attach conditions to how the gamete or embryo is used. For this reason, gamete and embryo donation should not be permitted without the free and informed consent of the donor, not only regarding the procedure and the risks of donating, but also the ultimate purpose of the donation. It is therefore essential that the donor be told how the donated gametes or embryo will be used.

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243. *Supra*, note 207 at 337.

244. In its working paper on experimentation, the LRC indicated that: "Gametes and human embryos cannot be considered to be simple cells or simple tissues. The first are the virtual sources of new human life; the second already have life." See *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

It would appear that at common law conditions may be attached to donations of organs and tissues that do not regenerate.[245] This is all the more reason why the donation of gametes and embryos should be subject to conditions, provided such conditions are not discriminatory.[246]

The right of a donor to withdraw his or her consent to a donation is provided for in Quebec civil law in article 20 *C.C.L.C.*[247] At common law, such right is determined by the nature of the contract. If the contract is deemed to be a contract for a service, the donor may withdraw his or her consent at any time. However, if the contract is for the sale of a good, the donor would not have the option of withdrawing consent.[248] We might ask whether it is appropriate that the revocable or irrevocable nature of the consent should depend on the nature of the contract (sale of a good or contract for a service). Are not the nature of the donated product and the significance of a donation of life sufficient to warrant the right to revoke a donation of gametes or embryos?

2. Gamete and Embryo Donations: Free and Anonymous

Under current law in the common law provinces, the sale of tissues and parts of the human body is generally prohibited by provisions which deem such sale to be "contrary to public policy."

> No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.[249]

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245. *Uniform Human Tissue Gift Act*, *supra*, note 236, s. 3(4): "If for any reason the tissue specified in the consent is not removed in the circumstances to which the consent relates, the consent is void." Section 8 provides: "Where a gift under this Part cannot for any reason be used for any of the purposes specified in the consent, the subject matter of the gift and the body to which it belongs shall be dealt with and disposed of as if no consent had been given." See, *e.g.*, the Alberta *Human Tissue Gift Act*, *supra*, note 236, ss 3(4), 8.

246. See Baudouin and Labrusse-Riou, *supra*, note 210 at 45: [TRANSLATION] "A donation of sperm is not a 'blind' donation, but rather a deliberate, directed donation, a conditional donation that is part of a true agreement between the donor, the physician and, through the physician, the recipient or recipients. Donating the potential for human life is not an ethically neutral act and must therefore be evaluated and respected as such."

247. See *supra* at 47. *An Act to add the reformed law of persons, successions and property to the Civil Code of Québec*, *supra*, note 235, art. 21, provides that consent may even be revoked verbally. Art. 24 of Bill 125, *supra*, note 196, provides likewise.

248. OLRC, *supra*, note 2 at 62.

249. See *Uniform Human Tissue Gift Act*, 1971, *supra*, note 236, s. 10. It should be borne in mind that most of the provinces patterned their legislation after this model. Section 10 was amended as follows, omitting the notion of public policy (*Uniform Human Tissue Donation Act*, 1989, *supra*, note 236):

The scope of this prohibition is not entirely clear, however. On the one hand, the definition of "tissue" excludes tissues that are capable of regeneration, which suggests that they are exempt from the prohibition. On the other hand, the language of the provision seems to indicate the intention also to include tissues that are capable of regeneration: "No person shall buy, sell ... *any tissue for a transplant*, or any body or part or parts thereof *other than blood or a blood constituent* [emphasis added]."[250]

In Quebec, article 20 *C.C.L.C.* permits the sale of parts of the body that are capable of regeneration.[251] We may therefore conclude that if gametes are considered as tissues or parts of the body capable of regeneration, donations would not necessarily have to be gratuitous.

However, the nature of gametes leads us to consider the appropriateness of prohibiting all commercialization of gametes,[252] permitting only the reimbursement of expenses[253] and limiting the circulation and storage of gametes to hospitals and non-profit fertility clinics. Similarly, we must consider the need to regulate the import of eggs and sperm. We must also ask the same questions with regard to embryo donation.

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15. (1) No person shall buy, sell or other-wise deal in, directly or indirectly, any tissue, body or body part for the purpose of a transplant or for a therapeutic purpose, medical education or scientific research.

(2) Any dealing in any tissue, body or body part that was lawful before this Act came into force shall continue to be lawful, provided this Act is complied with.

(3) A person who contravenes this section is guilty of an offence and liable on summary conviction to a fine of not more than $100,000 or to imprisonment for not more than 1 year, or to both.

As we saw (*supra*, note 239), the definition of "tissue" in this latest version of the *Uniform Human Tissue Donation Act*, *supra*, note 236, does not include spermatozoa, ova, embryos or fetuses.

250. *Ibid.* For more details on this matter, see the forthcoming LRC working paper *Procurement and Transfer of Human Tissues and Organs*.

251. *An Act to add the reformed law of persons, successions and property to the Civil Code of Québec*, *supra*, note 235, art. 22, provides: "The alienation of a part of the human body not capable of regeneration shall be gratuitous." Therefore, the sale of a part of the body that is capable of regeneration should be permitted. See Ouellette, *supra*, note 235 at 21-22. However, subarticle 22(2), which is new law, prevents exploitation by stating that "[t]he alienation of a part of one's body shall not be repeated if it involves a risk to the health." However, art. 25 of Bill 125, *supra*, note 196, drops the distinction for parts of the body that are capable of regeneration. See *supra*, note 210.

252. See *supra* at 41ff and notes 207 and 208.

253. Section 11.5 of *An Act to amend the Uniform Child Status Act*, *supra*, note 199, provides as follows:

(1) No person shall, directly or indirectly, buy, sell or otherwise deal in human eggs, sperm or embryos.

(2) A person who contravenes this section is guilty of an offence and liable on summary conviction to a fine of not more than $100,000, to imprisonment for not more than one year or to both.

(3) This section does not prohibit a person from giving or receiving reimbursement for reasonable expenses necessarily incurred in donating her own eggs or his own sperm.

Another characteristic of gamete and embryo donation is that it is normally made on the condition, implied or express, that the donor remain anonymous. Donors must therefore be assured adequate protection against disclosure of their identity.

If the donor is considered a "patient," he or she is protected, under both the civil law and the common law, by the rules of confidentiality that normally apply to patient-physician communications. Physicians have always been required, either by medical ethics or by the law, not to disclose the medical information in their patients' records.[254] "It is clear law that a physician owes a duty of confidence to his or her patient. This duty is recognized at common law, in at least two provinces by legislation and may even be constitutionally guaranteed."[255]

The two legal systems also share a rule whereby information may not be disclosed unless the patient gives his or her consent, or unless disclosure is required by law[256] or as a matter of public policy.[257]

Confidential information may also be disclosed in a court of law. However, the risk of such disclosure seems to be greater at common law because physicians do not enjoy any privileges as witnesses,[258] whereas in the civil law a physician is bound to maintain confidentiality in a legal proceeding unless the patient releases him or her from that duty.[259]

Given the special status of donors,[260] we might ask whether it is appropriate to make them subject to the same legal scheme that applies to patients. Moreover, since gamete and embryo donations are made within the very specific framework of medically assisted

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254. Rule 6 of the Canadian Medical Association, *Code of Ethics* (Ottawa: The Association, 1990) reads: "An Ethical Physician: ... 6. will keep in confidence information derived from a patient or from a colleague regarding a patient, and divulge it only with the permission of the patient except when otherwise required by law."

255. Donald G. Casswell, "Disclosure by a Physician of AIDS-related Patient Information: An Ethical and Legal Dilemma" (1989) 68 Can. Bar Rev. 225 at 228 n. 12. With respect to the common law, this author refers to the following decisions: *A.B.* v. *C.D.* (1851), 14 Dunlop's S.C. 177 (C. Sess., Scot.); *Furniss* v. *Fitchett*, [1958] 77 N.Z.L.R. 396 at 400 (S.C.); *Halls* v. *Mitchell*, [1928] S.C.R. 125 at 136; *Re Inquiry into Confidentiality of Health Records in Ontario* (1979), 24 O.R. (2d) 545 (C.A.), rev'd (*sub nom. Solicitor General of Canada* v. *Royal Commission of Inquiry into Confidentiality of Health Records in Ontario*), [1981] 2 S.C.R. 494 at 500-01. For Quebec, the author refers to the *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12, ss 5 and 9; the *Medical Act*, R.S.Q., c. M-9, s. 42; and the *Code of Ethics of Physicians*, R.R.Q. 1981, c. M-9, r. 4, s. 3.01.

256. Picard, *supra*, note 196 at 17-19; Gilbert Sharpe, *The Law and Medicine in Canada*, 2d ed. (Toronto: Butterworths, 1987) at 184-91.

257. Casswell, *supra*, note 255 at 231.

258. Knoppers, *supra*, note 196 at 125; see also *Halls* v. *Mitchell*, *supra*, note 255 at 136.

259. See *Medical Act*, *supra*, note 255, s. 42, and s. 9 of the Quebec Charter.

260. There is uncertainty both in Quebec and in the common law provinces about considering donors as patients. See the OLRC report, *supra*, note 2 at 83; and Bartha Maria Knoppers, "Vérité et information de la personne" (1987) 18 R.G.D. 819 at 830.

procreation, we cannot ignore the need for information of the other persons involved.[261] In light of these factors, it may be reasonable to consider the establishment of another scheme that would protect the donor's privacy and at the same time guarantee access to the medical, genetic and social information required by the other persons involved.

3. Donor Consent

As stated earlier,[262] because the human body is inviolable, the donation of sperm, ova and embryos requires the free and informed consent of the donor. In Quebec, article 20 *C.C.L.C.* states that such consent must be in writing. The same requirement exists in the other provinces that adopted section 3 of the *Uniform Human Tissue Gift Act*.[263] Further, in both civil and common law the risk incurred must not be disproportionate to the anticipated benefit.

Ovum donation, however, poses a special problem. In cases where consent was given for a procedure requiring egg retrieval (for any reason), it is not certain under the law as it now stands whether it is necessary to obtain the woman's consent to dispose of her eggs if she does not specify the purpose for which they are intended:

> Ova may be obtained ... for instance at a woman's sterilization, investigation for subfertility, or hysterectomy. Further, where superovulation is stimulated to assist a woman to become pregnant by I.V.F., any surplus ova may be available to others. ... It is not clear, however, that such sources of ova for I.V.F. of other women are legally required to give consent. If they take initiatives to control recovered ova, their wishes must be respected.[264]

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261. See *infra* at 157-60.

262. See *supra* at 46ff.

263. *Supra*, note 236. It should be noted, however, that the latest version of the Act available for adoption by the provinces does not require written consent. See *Uniform Human Tissue Donation Act*, *supra*, note 236, s. 5(1).

264. Bernard M. Dickens, "Reproduction Law and Medical Consent" (1985) 35 U.T.L.J. 255 at 283, refers to *Venner* v. *Maryland*, 354 A. 2d 483 at 499 (1976), in which the court ruled that "when a person does nothing and says nothing to indicate an intent to assert his right of ownership, possession, or control over such material, the only rational inference is that he intends to abandon the material."

See also OLRC, *supra*, note 2 at 89:

> Assuming that a property right or a right of possession rests in the producer of the human genetic material — and, therefore, assuming that such rights in the material do not automatically pass to the hospital or physician storing or working with it — questions still arise concerning, for example, whether these rights may be lost merely by a failure to assert them or whether, notwithstanding the absence of specific directions, the producer of the ova or semen may correctly assume that the hospital or physician is under a legal duty to destroy the unused material, with perhaps some routine examination by a pathologist, but not experimentation.

Despite the existence of more general consent, the special nature of ova and the significance of the donation for the woman should justify the need for specific donor consent.

Consent to embryo donation raises other problems. Whether the embryo is derived from the gametes of the two spouses or was conceived using gametes from only one of the spouses and a donor, we may ask whose consent is required.[265] Finally, as discussed earlier,[266] the revocability of consent respecting a donation raises a number of issues for the common law provinces.

4. Donor Liability

A donor who provides false information or fails to disclose information about his or her medical history can endanger the child and the mother. If the donor conceals the fact that he or she carries a genetically transmissible disease and the child born using the gametes he or she donated is affected, the donor may beld liable. The donor would thus have a duty to disclose.

But who would be able to take action against the donor? In the civil law, [TRANSLATION] "a child that is conceived but not yet born enjoys some legal recognition, conditional on its birth."[267] At common law, an action for "wrongful birth" is also open to the parents and the child.[268]

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265. Knoppers, *supra*, note 196 at 99-100.

266. See *supra* at 51.

267. Baudouin and Labrusse-Riou, *supra*, note 210 at 57; Michèle Rivet, "Le droit à la vie ou 'l'hominisation' du XXIe siècle: l'éthique et le droit répondent à la science" in Daniel Turp and Gérald A. Beaudoin, eds, *Perspectives canadiennes et européennes des droits de la personne* (Cowansville, Que.: Yvon Blais, 1986) 445 at 457; Bartha Maria Knoppers, "Modern Birth Technology and Human Rights" (1985) 33 Am. J. Comp. L. 1 at 16-17; Edward W. Keyserlingk, *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective* (Montreal: Quebec Research Centre of Private and Comparative Law, 1984) at 57-59.

268. Baudouin and Labrusse-Riou, *supra*, note 210 at 57; Knoppers, *supra*, note 267 at 16-17:

> The protection of the unborn from negligent injury under the common law was first established with regard to its proprietary and successoral interests from conception onwards, provided the child was born alive. . . . Similarly, the common law in the United States and Canada has either adopted the notion of a pre-existing duty not to harm, or a conditional prospective duty, which crystallizes at birth as the basis for tortious liability. Another recent common law notion is the causal approach, which separates the concepts of injury and damage and looks simply at the causal link between the infant's condition at birth and the defendant's wrongful conduct, thus avoiding the issue of legal personality and the moment of injury altogether.

However, donor anonymity, evidentiary problems and the difficulty of establishing a causal link would make such legal action virtually impossible.[269] Moreover, a liability suit could more easily be taken against the gamete and embryo bank for its failure in the selection and screening phases, or against the physician in charge.

Nevertheless, it should be noted that there is a public-order dimension to donor liability.[270] A donor could be held criminally liable if, for example, he knew he was carrying a potentially fatal virus, still donated his sperm and deliberately withheld the information. It is therefore important that donors at least be identifiable and that their identity be revealed in the event of criminal prosecution for failure to disclose information.

C. Children

1. Legal Parentage

Parentage law organizes the legal relationships between a child and his mother and father.[271] Parentage gives rise to certain rights and obligations, such as the obligation of

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Dickens, *supra*, note 221 at 262:

> Liability for pre-conception torts has recently been recognized under Common Law reasoning, so it may not matter whether the ovum was fertilized or unfertilized when damage occurred. Recognition of pre-conception torts has emerged only recently, however, and upon the basis of United States decisions, so that their status in Canada is at present unavoidably unclear.

See *Jorgensen* v. *Meade Johnson Laboratories, Inc.*, 483 F. 2d 237 at 240 (1973), in which Judge Holloway ruled:

> If the view prevailed that tortious conduct occurring prior to conception is not actionable in behalf of an infant ultimately injured by the wrong, then an infant suffering personal injury from a defective food product, manufactured before his conception, would be without remedy. Such reasoning runs counter to the various principles of recovery which Oklahoma recognizes for those ultimately suffering injuries proximately caused by a defective product or instrumentality manufactured and placed on the market by the defendant. . . .
>
> We are persuaded that the Oklahoma courts would treat the problem of the injuries alleged here as one of causation and proximate cause, to be determined by competent medical proof. . . . And such treatment of the problem would accord with the predominant view that an action may be maintained for prenatal injuries negligently inflicted if the injured child is born alive.

See also *Renslow* v. *Mennonite Hospital*, 351 N.E. 2d 870 (1976).

269. Bartha M. Knoppers and Elizabeth Sloss, "Recent Developments: Legislative Reforms in Reproductive Technology" (1986) 18 Ottawa L. Rev. 663 at 687-88.

270. *R.* v. *Thornton* (15 June 1989), Ottawa-Carleton 1814 (Ont. Dist. Ct), aff'd (1991) 1 O.R. (3d) 480 (C.A.). This very recent ruling by the Ottawa District Court found an individual guilty of public nuisance because he voluntarily donated his blood to the Red Cross even though he knew he was carrying the AIDS virus.

271. Mireille D.-Castelli, *Précis du droit de la famille* (Quebec: P.U.L., 1987) at 119.

parents to feed, care for and educate their children. Legal parentage also has an impact on the law of successions. The legal bond can be established by the biological link (parentage by blood) or by an act of will (adoption). How then is the parentage of children born as a result of medically assisted procreation to be determined?

Traditionally, the establishment of maternal filiation throught the fact of childbirth[272] reflected a biological and genetic certainty. Marriage, a social reality, made it possible to resolve the uncertainty of paternity by a presumption which, while favouring the social aspect of paternity, usually reflected a biological reality.

Some legislatures have over the years eased the traditional rules governing filiation by abolishing the distinction between illegitimate children and legitimate children[273] and recognizing the predominance of biological truth.

In the common law provinces, however, there appears to be disparity between those that establish parentage solely on the basis of marriage and those that have passed laws to ease this common law rule by abolishing the difference between illegitimate and legitimate children.[274]

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272. *Ibid.* With respect to the common law, see Dickens, *supra*, note 218 at 69-70, and Knoppers, *supra*, note 221 at 339-40. This traditional view in Canadian law is expressed by the maxim *Mater est quam gestatio demonstrat.* John K. Mason and Robert A. McCall-Smith, *Law and Medical Ethics*, 2d ed.(London: Butterworths, 1987) at 47.

273. With respect to the civil law see D.-Castelli, *supra*, note 271 at 122; with respect to the common law see Margo Wilson, "Impact of the Uncertainty of Paternity on Family Law" (1987) 45 U.T. Fac. L. Rev. 216 at 232. See *infra*, note 283.

274. *Canadian Family Law Guide* (Don Mills, Ont.: Commerce Clearing House Canadian, 1989) at 2401, para. 4305; see *infra*, note 283. A decision in British Columbia, *Gartrell* v. *Carlsen* (1987), 13 B.C.L.R. (2d) 56 (Prov. Ct), states: "The enactment of subsection 56(1) of British Columbia's *Law and Equity Act* had the effect of making biological parenthood the only kind known to provincial law, and of abolishing the presumption of legitimacy."

Subsection 56(1) of the *Law and Equity Act*, R.S.B.C. 1979, c. 224, as am. S.B.C. 1985, c. 68, s. 80, reads:

> Subject to the *Adoption Act* and *Family Relations Act*, for all purposes of the law of British Columbia,
>
> (*a*) a person is the child of his natural parents,
> (*b*) any distinction between the status of a child born inside marriage and a child born outside marriage is abolished, and
> (*c*) the relationship of parent and child and kindred relationships flowing from that relationship shall be determined in accordance with this subsection.

It should be noted, however, that these changes have sparked controversy, both in Quebec and in the common law provinces, regarding the priority to be given to the various means of proving parentage.[275]

It is questionable whether the legislatures truly intended to choose between the biological and social aspects of parentage. Indeed, whether they established the certainty of maternity and the presumption of paternity or did away with the difference between legitimate and illegitimate children, was their objective to preserve the child's interest, or were they more concerned about ensuring a clearer application of the law (better administration of justice)?

While it is as difficult to determine what the current rules on parentage should reflect (social likelihood or biological truth) as it is to identify legislative intent, applying and adapting the rules to medically assisted procreation is becoming especially problematic. Problems that may arise include: the attribution of the responsibilities of fatherhood to a husband who did not consent to the conception of the child (or to a donor who had absolutely no intention of being a father[276]; disavowal of a child originally wanted[277] by

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This suggests that in the provinces where this traditional distinction has been abolished, the law would still conceal the biological truth under the presumption of legitimacy related to marriage and would thus favour a social truth. However, the British Columbia Supreme Court ruled as follows in *B. (B.J.)* v. *K. (J.)* (1989), 56 D.L.R. (4th) 150 at 158:

> While it is correct to say that s. 56 of the *Law and Equity Act* has, by abolishing "any distinction between the status of a child born inside marriage and a child born outside marriage" abolished the *status* of illegitimacy ... it certainly has not abolished the reality of what we know as "legitimacy" and "illegitimacy". ...
>
> In my opinion, it would require a clear and unambiguous expression of intention by the legislature to displace such a longstanding presumption, which, in my view, provides a just and useful rule. ...
>
> As no such clear and unambiguous expression appears in s. 56 of the *Law and Equity Act*, I hold that the presumption of legitimacy remains in effect in British Columbia.

275. For Quebec, see Jean Pineau, *La Famille* (Montreal: P.U.M., 1982) at 198-202; Michèle Rivet, "La vérité et le statut juridique de la personne en droit québécois" (1987) 18 R.G.D. 843 at 848: the author refers to *Trudeau* v. *Arial*, [1981] S.C. 727, *Droit de la famille-6* (2 December 1982), Québec 200-09-000070-802, J.E. 83-76 (C.A.). Knoppers, *supra*, note 260 at 829, clearly illustrates the ambivalence of the Civil Code on this matter. For the common law position, see *supra*, note 274, and the report of the OLRC, *supra*, note 2 at 64-78.

276. See, *e.g.*, s. 56(1)(*a*) of the *Law and Equity Act*, *supra*, note 274.

277. Subject to art. 586 *C.C.Q.* in Quebec; s. 13(3) of the *Children's Act, supra*, note 197, in the Yukon; and s. 12(3) of *The Children's Law Act*, *supra*, note 197, in Newfoundland.

parents who change their mind at some point during the procedure; and the possibility of a challenge of paternity by third parties or the donor and a claim of paternity by the donor.[278]

Application of the current rules governing parentage to technologies that use donated ova has had the effect, for the first time, of dividing maternal biological filiation into genetic filiation and gestational filiation. This situation has faced lawmakers with a choice that they could not have foreseen: Should gestation and delivery prevail over genetic link?

2. Biological Parentage

Children may wish to trace their origin, either to obtain the medical histories of their forebears or to satisfy a psychological need to establish their identity. We can safely say that a child's interest in knowing about his or her medical and genetic history meets with little objection in our society.[279] In practice, however, access to such information is not guaranteed:

> A major inadequacy of present legislative regimes is that, even when they accommodate the preferences of active participants in artificial insemination, as in the case of A.I.D. [artificial insemination with donor], they do not necessarily protect the children consequently

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278. See Dickens, *supra*, note 218 at 68; Canadian Bar Association, *Report of the Special Task Force Committee on Reproductive Technology of the British Columbia Branch*, 1989 at 13 [unpublished]. See arts 586 and 588 *C.C.Q.* and art. 580 of Bill 125, *supra*, note 196. The Yukon has provided for the absence of a legal relationship between a donor and a child born of the product of the donation if the donor is not the husband of the mother: *Children's Act*, *supra*, note 197, s. 13(6). In *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.4(2) provides that: "A man whose sperm is used in an assisted conception and who is not presumed to be the father of a child pursuant to section 9 is deemed not to be the father of the child."

    Art. 579 of Bill 125, *supra*, note 196, is similar:

    > Participation in the parental project of another person by way of a contribution of genetic material to medically assisted procreation does not allow the creation of any bond of filiation between the contributor and the child born of that procreation.

279. Baudouin and Labrusse-Riou, *supra*, note 210 at 55; and Bernard M. Dickens, "Legislating for the Brave New Children" in Barbara Landau, ed., *Children's Rights in the Practice of Family Law* (Toronto: Carswell, 1986) 345 at 347. To ensure that records are kept on the genetic origin of children born as a result of medically assisted procreation and that access to those records is made possible, s. 11.6 of *An Act to amend the Uniform Child Status Act*, *supra*, note 199, provides that:

born. . . . A larger problem concerns children born of donated sperm and/or ova, whose medical care and later reproductive counselling may be dependent upon knowledge of their genetic parentage. The absence of means of tracing at least genetic profiles of biological parents may place them at a disadvantage and perhaps at risk. The adoption model may expose children to disadvantage, but it usually permits discovery of at least a birth mother's characteristics; the practice of birth through donated sperm or ova reveals a default of legislative attention that exposes an increasing number of children to the risk of grave disadvantage to health.[280]

Further, access to this information, assuming it were available, raises the problem of disclosure of the use of a donation from a third party to the conception. We therefore have to decide whether such disclosure should be left to the parents' discretion or whether the child should be recognized as having a right to the information upon reaching the age of majority.

The notion of the child wanting information because of a psychological need to establish his or her identity is not unfamiliar. It is being recognized more and more in the context of adoption. Systems have been put into place to enable adopted children to search for

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(1) Every duly qualified medical practitioner who carries out procedures that are intended to result in an assisted conception shall maintain, in the form and manner prescribed in the regulations, records indicating the donor and recipient of every egg or sperm used in the assisted conception procedures.

(2) Every duly qualified medical practitioner who carries out procedures that are intended to result in assisted conceptions shall submit information within the knowledge of the practitioner with respect to

(a) assisted conceptions that result from procedures carried out by the practitioner,

(b) births resulting from assisted conceptions that result from procedures carried out by the practitioner, and

(c) procedures carried out by the practitioner that are intended to result in assisted conception, where the practitioner does not know whether conception was or was not achieved.

(3) Every duly qualified medical practitioner shall submit information within the knowledge of the practitioner with respect to births of children delivered by the practitioner that result from assisted conceptions.

(4) The information mentioned in subsection (2) or (3) is to be submitted to the agency designated in the regulations in the form and manner and at the times prescribed in the regulations.

(5) The agency that receives information pursuant to subsection (4)

(a) shall maintain a permanent registry of the information, and

(b) shall not disclose or communicate the information except in accordance with the terms and conditions prescribed in the regulations.

(6) The Lieutenant Governor in Council [or other regulation making authority in the jurisdiction] may make regulations prescribing any matter or thing that is required or authorized by this section to be prescribed in the regulations.

280. Dickens, *supra*, note 279 at 355; see also Knoppers, *supra*, note 267 at 15 n. 64.

their biological parents.[281] In the area of medically assisted procreation, however, because of the confusion over record keeping and the "protection" afforded the donor's anonymity, children are generally denied the right to know about their origins.[282]

We must first ask whether it is appropriate to compare the situation of children born as a result of a donation with that of adopted children and then question the appropriateness of granting them the right to know about their origins or certain rights to information. In any event, it is important to find a middle ground so that the privacy of the donor and the parents is protected. Should no formal right to information be granted, we would anticipate cases in which anonymity might be lifted.

3. Legal Status

Most provinces and territories in Canada have done away with the distinction between legitimate and illegitimate children,[283] but some, such as Alberta and Nova Scotia, have not.

In these provinces, children conceived by use of donated gametes or embryos will be denied the benefits enjoyed by legitimate children, not only in cases where the parents are not married, but also in cases where it is proved that the child was conceived as a

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281. In Quebec, *e.g.*, a summary of the child's history may be delivered upon request to an adoptive parent or to the child if he or she is aged 14 years or older, provided anonymity is respected (*Youth Protection Act*, R.S.Q., c. P-34.1, ss 131.1 and 131.2). Further, the legislature has provided for the reunion of biological parents and adoptees who have reached the age of majority (art. 632 *C.C.Q.*). The search takes into account the intentions of the parties. See, *e.g.*, art. 632 *C.C.Q.* (reiterated in art. 577 of Bill 125, *supra*, note 196) and, in Ontario, Ministry of Community and Social Services, *Adoption Disclosure Services* (Toronto: Queen's Printer for Ontario, 1987). It should be noted, however, that in Quebec, art. 583 of Bill 125, *supra*, note 196, provides for the confidentiality of identifying information about those involved in the medically assisted procreation of a child. An exception is made where confidentiality could cause grave injury to the child's health.

282. According to a study in the United States, barely one-third of the physicians interviewed kept permanent records on children conceived by artificial insemination, and fewer than one-third kept permanent records on donors. See Martin Curie-Cohen, Lesleigh Luttrell and Sander Shapiro, "Current Practice of Artificial Insemination by Donor in the United States" (1979) 300:11 New Engl. J. Med. 585 at 588, quoted in Ann T. Lamport, "The Genetics of Secrecy in Adoption, Artificial Insemination, and *In Vitro* Fertilization" (1988) 14:1 Am. J. L. Med. 109 at 116-17, particularly at 118: "Often the semen used in artificial insemination is collected by a urologist and the insemination [is] done by an obstetrician who may not actually deliver the child."

283. The *Civil Code of Québec* has removed the existing inequities between the different known types of filiation: legitimate, natural and adulterine. See art. 594 *C.C.Q.* (reiterated in art. 536 of Bill 125, *supra*, note 196). See also *Law and Equity Act* (B.C.), *supra*, note 274, s. 56(1); *Child Status Act*, R.S.P.E.I. 1988, c. C-6, s. 1(1) and (4); *Family Services Act*, S.N.B. 1980, c. F-2.2, s. 96(1) and (4); *The Family Maintenance Act*, R.S.M. 1987, c. F20, s. 17; *Children's Law Reform Act* (Ont.), *supra*, note 228, ss 1(1) and (4) and 2(1); *Judicature Act*, R.S.N.W.T. 1988, c. J-1; *Children's Act* (Yukon), *supra*, note 197, s. 5(1) and (4); *The Children's Law Act* (Nfld), *supra*, note 197, s. 3; *The Children's Law Act*, S.S. 1990, c. C-8.1, s. 40; and *Uniform Child Status Act*, *supra*, note 199, s. 2.

result of a donation[284] (despite the fact that artificial insemination with donor is no longer considered adultery). Even though the presumption of paternity covers AID by making the husband the father of the child, there are questions to be asked regarding the appropriateness of clarifying the legal status of children born as a result of gamete or embryo donation:

> [W]here the distinction exists between legitimacy and illegitimacy, the children of proven A.I.D. [artificial insemination with donor] are held to be illegitimate, with all of the legal disadvantages they bear in their social families due to that status. The fact of A.I.D. is frequently concealed, because children born to married women are legally presumed to be their husbands', and no one has an interest to rebut that presumption.[285]

D. Medical Personnel

1. Liability of Physicians

A physician incurs liability when he or she acts in a negligent manner in administering treatment. However, physicians are held only to an obligation of means — or general duty of prudence and diligence —, not to an obligation of result — or absolute duty.[286]

In medically assisted procreation, negligence on the part of the physician may occur before or after conception. Negligence may pertain to the administration of the procedure used, the performance of the duty to inform[287] or the respect of the duty of confidentiality.[288] For the purposes of our study, we will look specifically at the duty to inform, which stems from the duty of every physician to obtain the free and informed consent of his or her patient.[289]

The scope of this obligation to inform appears to vary depending on whether the treatment is therapeutic, elective or experimental. Although the Supreme Court[290] did not

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284. Bartha Maria Knoppers, "Women and the Reproductive Technologies" [1985] Fam. L. Can. 211 at 220; there is always the possibility of an application for legitimation: *Legitimacy Act*, R.S.A. 1980, c. L-11; *Family Maintenance Act*, R.S.N.S. 1989, c. 160, s. 49.

285. Dickens, *supra*, note 279 at 347.

286. Baudouin and Labrusse-Riou, *supra*, note 210 at 57.

287. *Ibid.*; Picard, *supra*, note 196 at 67ff.

288. Baudouin and Labrusse-Riou, *supra*, note 210 at 58; Sharpe, *supra*, note 256 at 181ff. This matter has already been discussed; see *supra* at 53.

289. The requirement of consent flows from application of the rule, protected by the civil law, the common law and the criminal law, that a person's physical integrity may not be violated without the person's consent. With respect to the criminal law, see LRC, *Recodifying Criminal Law: Revised and Enlarged Edition of Report 30*, Report 31 (Ottawa: The Commission, 1987) at 61.

290. Picard, *supra*, note 196 at 92.

comment specifically in *Reibl* v. *Hughes* or *Hopp* v. *Lepp*[291] on the scope of the duty to inform in cases of elective surgery, other decisions, both in the civil law and the common law, interpret the obligation more broadly.[292]

In the field of research, the obligation to disclose information and risks would be even stricter. "Not only must the research subject consent but his or her consent must be explicit and based on what might well be called a 'perfect' disclosure."[293]

The problem in medically assisted procreation is determining whether the different technologies that are used are therapeutic, elective or experimental treatments and, consequently, what standard of disclosure should be required.

Although it is not within the scope of our study to decide this matter, we feel it would be desirable for our courts, in considering this issue, to take into account the specific characteristics of each technology (risks, success rates, and so on).[294]

2. Liability of Gamete and Embryo Banks

Donor selection is vital because it not only increases the chances of success, but also protects the health of the person receiving the donation and prevents the transmission of serious infectious or genetic diseases.[295] Since it was discovered that the AIDS virus can be transmitted through sperm, physicians have begun using frozen sperm for insemination.

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291. *Supra*, note 238.

292. With respect to the common law, see Picard, *supra*, note 196 at 93:

> In interpreting the Supreme Court of Canada's decision in *Reibl* v. *Hughes* [*supra*, note 238], the provincial courts have said that for an elective procedure, minimal or possible risks and alternative procedures and their comparative risks must be explained voluntarily. . . . There is authority for requiring a doctor effecting a sterilization to explain other methods or techniques. It would seem that this can be generalized to cover any elective procedure.

With respect to the civil law, see *Blais* v. *Dion* (27 September 1985), Montréal 500-05-008454-835, J.E. 85-934 at 11 (Sup. Ct); *Dulude* v. *Gaudette*, [1974] C.S. 618 at 621; *Hamelin Hankins* v. *Papillon*, [1980] C.S. 879 at 881. On the current controversy over the risks to be disclosed in cases of plastic surgery, see Louise Potvin, *L'obligation de renseignement du médecin* (Cowansville, Que: Yvon Blais, 1984) at 29-31.

293. Picard, *supra*, note 196 at 118. See also *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 30ff. In Canada, the decision in *Halushka* v. *University of Saskatchewan* (1965), 53 D.L.R. (2d) 436 (Sask C.A.), set the standard and scope of the duty to disclose in the area of experimentation. See at 444: "The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent. . . . There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice."

See also the recent decision by the Quebec Superior Court in *Weiss* v. *Solomon*, [1989] R.J.Q. 731.

294. See chap. 1.

295. Lori B. Andrews, *Medical Genetics: A Legal Frontier* (Chicago: American Bar Foundation, 1987) at 168: "[S]ome women who have been inseminated with donor sperm have contracted venereal disease from the sperm. In addition, children have been born with genetic defects that were passed on by the sperm donor."

Gamete and embryo banks may be liable if they are negligent in screening for genetic defects and diseases. In the civil law, "the laboratory is held to an obligation of result and in the case of error will have to exculpate itself by demonstrating some external force or event."[296] In the common law, "since the standard of care is proportionate to the risks involved, the standard of care could very well be the same."[297]

Unlike donations of other human products, such as blood,[298] the donation of gametes and embryos is not currently subject to any national regulatory scheme. In 1977, an advisory committee examined the question of the storage and use of human sperm; in 1981, the committee submitted a report to the Minister of National Health and Welfare. One of the committee's recommendations was that "[f]ederal regulations governing standards for the acquisition, preservation and importation of human sperm be established."[299] In 1988, the Canadian Fertility and Andrology Society adopted guidelines dealing, among other things, with the selection of donors and genetic screening. However, as stated in the preface, the document was "not intended to be exhaustive, nor to replace any other guidelines or be considered as a rigid set of procedures and standards."[300]

The author refers to William G. Johnson, Robin C. Schwartz and Abe M. Chutorian, "Artificial Insemination by Donors: The Need for Genetic Screening" (1981) 304:13 New Engl. J. Med. 755; David N. Shapiro and Raymond J. Hutchinson, "Familial Histiocytosis in Offspring of Two Pregnancies after Artificial Insemination" (1981) 304:13 New Engl. J. Med. 757. See also *supra*, chap. 1.

296. Knoppers, *supra*, note 267 at 10 n. 47.

297. *Ibid.*

298. The *Food and Drugs Act*, R.S.C. 1985, c. F-27 and the *Food and Drug Regulations* (C.R.C. 1978, c. 870) have set standards respecting, *inter alia*, advertising, labeling, sale, import, processing, storage and the number of donations permitted. The Canadian Red Cross Society also has standards respecting some of these subjects; see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

299. *Report on Human Sperm 1981, supra,* note 148 at xii.

300. Canadian Fertility and Andrology Society, *supra*, note 11 at 3; current practice is therefore fraught with uncertainty respecting the application of uniform criteria. The OLRC wrote in 1985:

> Practices respecting donor screening appear to vary considerably. The most common tests, which are either given by the doctors or required by them to be done in a laboratory, are blood group and type, semen analysis and culture, and VDRL [Venereal Disease Research Laboratory]. Less frequent tests are CBC [Complete Blood Count] and hepatitis, with still fewer responses reporting karotype [sic], genetic screening, and the taking of a family or general history of the donor. Other tests were listed by some practitioners.

The rapid development of medicine makes it difficult to regulate medical selection and the prescription of genetic screening tests. On the other hand, the tremendous uncertainty regarding the uniform application of selection criteria and storage and import standards poses a risk for the unborn child and the future parents. It is therefore important to determine who should be responsible for ensuring the uniformity of the standards used and how this should be carried out. Could the medical profession alone take on this task?

We should also point out that gamete and embryo banks have a duty to respect the donor's consent and may be held liable if they show negligence in the storage of gametes and embryos.

We have seen that many rules of law apply to medically assisted procreation, but in general few are adapted to this new reality. In the chapter listing our recommendations, we will endeavour to address the problems identified in this first section. We will now examine the specific problems posed by surrogate motherhood.

II. Surrogate Motherhood

A. Issues

1. Legality and Legitimacy[301]

As the law now stands, surrogacy runs counter to the principles of contract law. For both the civil and the common law, any contract or agreement, even where there is no payment, between a surrogate and prospective parents is quite probably null and void as

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OLRC, *supra*, note 2 at 22.

Further, there are doubts as to the ability of practitioners to carry out appropriate genetic screening of donors. See Lamport, *supra*, note 282 at 117. The author refers to Curie-Cohen, Luttrell and Shapiro, *supra*, note 282 at 588:

> Geneticists and others recognize that there is a serious lack of knowledge of genetics in those who perform artificial insemination. Donors are commonly screened for hereditary disorders, but the screening is illusory. Family histories are taken, but they are usually superficial. Biochemical testing is only performed in about 28.8% of the cases. . . . Of the doctors participating in the Curie-Cohen study, 92% said that they would reject a donor with a chromosomal translocation or trisomy, but only 12.5% actually examined the potential donor's karyotype to see if the chromosomes were abnormal. Also, 71.4% said that they would reject a donor who had hemophilia in his family, despite the fact that it is an X-linked trait and would be impossible for a man to transmit unless he carried the gene and exhibited the trait himself.

Lamport writes, "[t]o date, this is the only study of its kind." See also Barratt, Chauhan and Cooke, *supra*, note 161; and "Screening Gamete and Embryo Donations," *supra* at 32.

301. See *supra*, note 231.

being against public policy.[302] Moreover, such contracts are also at odds with a fundamental principle of family law: the custody of a child must be determined according to the best interests of the child rather than the wishes expressed by the parents in a contract.[303] Any agreement providing in advance for the handing over of the child at birth is illegal under provisions dealing with parental authority.[304]

Clearly, the absolute nullity of such an agreement does not prevent the parties from giving effect to a contract where the surrogate does not object to surrendering the child.[305]

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302. With respect to the common law, see Dickens, *supra*, note 218 at 71: "It is commonly accepted that, in the absence of approving legislation, surrogate motherhood agreements will be held void by the courts as against public policy." OLRC, *supra*, note 2 at 220: "Although not otherwise prohibited, it would appear that such arrangements are illegal and unenforceable at common law as being against public policy." With respect to the civil law, see Baudouin and Labrusse-Riou, *supra*, note 210 at 115; art. 582 of Bill 125, *supra*, note 196, is explicit: "Procreation or gestation agreements on behalf of another person are null." Recall, also, the U.S. decision in *Baby M*, 537 A. 2d 1227 at 1234 (N.J. 1988): "We invalidate the surrogacy contract because it conflicts with the law and public policy of this State."

303. The precedence of the best interests of the child over contractual freedom is made clear in such provisions as ss 52(1)(c), 53(1)(c) and 56(1) of Ontario's *Family Law Act, 1986*, *supra*, note 196. For example, s. 52(1)(c) reads:

> 52(1) A man and a woman who are married to each other or intend to marry may enter into an agreement in which they agree on their respective rights and obligations under the marriage or on separation, on the annulment or dissolution of the marriage or on death, including,
>
> . . .
>
> (c) the right to direct the education and moral training of their children, but not the right to custody of or access to their children; . . .

Paragraph 53(1)(c) provides likewise for persons "who are cohabiting or intend to cohabit." See also s. 56(1): "In the determination of a matter respecting the support, education, moral training or custody of or access to a child, the court may disregard any provision of a domestic contract pertaining to the matter where, in the opinion of the court, to do so is in the best interests of the child."

304. With respect to the common law, see the OLRC report, *supra*, note 2 at 99: "With respect to the common law . . . the courts have long held that, subject to very few exceptions, parental rights and responsibilities are inalienable and incapable of transfer as a matter of contract." The illegality of such an agreement would be determined primarily by the interests of the child. Thus the Supreme Court has recognized that some custody agreements, the main objective of which were the best interests of the child, were not illegal; see *Chisholm* v. *Chisholm* (1908), 40 S.C.R. 115. *A contrario*, see *Re Hutchinson* (1913), 28 O.L.R. 114 (C.A.). See the discussion of surrogacy contracts and transfer of custody of the child in the OLRC report, *supra*, note 2 at 94-102. With respect to the civil law, see Rivet, *supra*, note 275 at 850: [TRANSLATION] "Abandoning in an agreement the rights that derive from parental authority is contrary to public policy, as is complete and definitive delegation of parental authority." The author refers to *Stevenson* v. *Florant*, [1925] S.C.R. 532; see also Jean-Louis Baudouin, *Les obligations*, 3d ed. (Cowansville, Que: Yvon Blais, 1989) at 83-84.

305. OLRC, *supra*, note 2 at 99-100:

> While a surrogate motherhood agreement may not be enforced as a matter of contract law, the existing legal regime does not make it completely impossible to give effect to the wishes of

We should point out, however, that this is made possible only through the application of rules governing filiation in both the civil law and the common law.[306]

Since the current law does not sanction surrogate motherhood and indirectly even permits it, we must ask if it would be appropriate to alter the situation. If so, legislation could be introduced that would make surrogacy contracts legal and set out the terms and conditions governing them, or would specifically prohibit such contracts as being contrary to public policy.

> [Translation]
> It may be that culture and traditional family law are drastically altered by the notion of surrogate motherhood, but surrogacy should not necessarily be seen as something negative to be restricted or prohibited. The mere fact of surrogacy means that a choice must be made between confirmation and prohibition in positive law.[307]

2. Commercial Aspects of Surrogacy

The monetary aspect of a surrogacy contract raises not only the potential for exploitation of the parties, but also the prospect of trade in children, which is currently prohibited in Canada by adoption and youth protection legislation:

> Though each Canadian province has its own legislation governing adoption, the basic statutory framework is similar throughout the country. The legislation restricts who may adopt a child and who may be adopted. Throughout North America concern exists about a practice sometimes known as baby farming, the unscrupulous placement of babies for adoption by operators motivated by a desire for profit and invariably acting with little regard for the welfare of the child. As a result, legislation restricts who may arrange adoptions and how they are to be arranged; in particular, there are restrictions about receiving payment for placing a child or doing other work in connection with an adoption.[308]

> the parties to such an agreement. There are procedures by which a child, born or about to be born to a surrogate mother, might be "naturalized" in the care and custody of the prospective social parents, at least where the social father is also the biological father. The focus of attention here is not on the validity or enforceability of a surrogate motherhood agreement, but on the steps that may be taken today where a child is born or about to be born and the surrogate mother is willing to transfer the child.
>
> See also Baudouin and Labrusse-Riou, *supra*, note 210 at 127-28; Rivet, *supra*, note 275 at 850-51, regarding the use of adoption rules in Quebec.

306. See *infra* at 69ff.

307. Baudouin and Labrusse-Riou, *supra*, note 210 at 120.

308. Nicholas Bala, Heino Lilles and Georges Thomson, *Canadian Children's Law* (Toronto: Butterworths, 1982) at 284-85.

For example, subsection 33(2) of *The Adoption Act* of Saskatchewan reads as follows:

> (2) [N]o person shall:
>
> (a) give or receive; or
>
> (b) agree to give or receive;
>
> any payment or reward, whether directly or indirectly, for any purpose related to the adoption of a child.[309]

Since it is illegal to receive payment in return for arranging the adoption of a child, these provisions may also prohibit a surrogate who consents to the adoption of her child from being reimbursed for expenses.[310]

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309. *The Adoption Act*, S.S. 1989-90, c. A-5.1. In Quebec, see s. 135.1 of the *Youth Protection Act*, *supra*, note 281:

> Whether the placement or the adoption takes place in Québec or elsewhere and whether or not the child is domiciled in Québec, any person who
>
> (*a*) gives or receives or agrees to give or receive, directly or indirectly, a payment or a benefit either for finding a placement or contributing to a placement with a view to adoption, or for obtaining the adoption of a child, ...
>
> is guilty of an offence and liable, on summary proceedings, in addition to costs, to a fine of $2 000 to $5 000, in the case of an individual, and to a fine of $5 000 to $10 000, in the case of a corporation.

This provision does not, however, invalidate the placement or adoption. See also *Child Welfare Act*, S.A. 1984, c. C-8.1, s. 71, as am. S.A. 1988, c. 15, s. 35; *Family Services Act*, (N.B.), *supra*, note 283, s. 95; *The Child and Family Services Act*, S.M. 1985-86, c. 8, ss 63 and 84; *The Adoption of Children Act, 1972*, S.N. 1972, No. 36, s. 5, as am. S.N. 1974, No. 9, s. 3 and S.N. 1979, c. 35, Sch. A, Item 1; *Child Welfare Act*, R.S.N.W.T. 1988, c. C-6, s. 108; *Children and Family Services Act*, S.N.S. 1990, c. 5, s. 69(3); *Adoption Act*, R.S.P.E.I. 1988, c. A-4, s. 23; *Children's Act* (Yukon), *supra*, note 197, s. 102. Ontario and British Columbia permit payment under certain conditions; see *Child and Family Services Act, 1984*, S.O. 1984, c. 55, ss 159-160, as am. S.O. 1987, c. 4, s. 8, and S.O. 1989, c. 72, s. 20, and *Adoption Act*, R.S.B.C. 1979, c. 4, as am. S.B.C. 1980, c. 36, s. 2. A decision by the British Columbia Supreme Court allowed the natural mother to be reimbursed by the adoptive couple for reasonable expenses related to the adoption of her child. Justice Huddart specified, however, "On another day and in other circumstances another judge might have different criteria but the adopting parents have established to my satisfaction that my criteria for approving a payment to the natural mother have been met.": *Re Adoption Act* (1982), 27 R.F.L. (2d) 72 at 75.

310. Dickens, *supra*, note 218 at 71: "Known participants complying with their terms in Canada have not been subjected to legal proceedings, for instance for violation of prohibitions against offering and receiving money for consent to adoption." For more information, see the U.S. decisions in *Baby M*, *supra*, note 302; *Doe* v. *Kelley*, 307 N.W. 2d 438 (1981), *certiorari* denied, 459 U.S. 1183 (1983); *Baby Girl*, 9 Fam. L. Rep. 2348 (1983), in which Justice Mudd refused to recognize the adoption of a child born to a surrogate mother by the genetic father and his wife. See also *Syrkowski* v. *Appleyard*, Civ. Action 81, 122 D.P. (1981), confirmed by 333 N.W. 2d 90 (1983) at 90: "The Court of Appeal, Cynar, P.J., held that the Paternity Act did not encompass the birth of a child which resulted from a financial transaction involving a surrogate mother." See, however, the opposite view in *In the Matter of Adoption of Baby Girl L.J.*, 505 N.Y.S. 2d 813 (1986), and *Surrogate Parenting Associates* v. *Commonwealth of Kentucky, ex rel Armstrong*, 704 S.W. 2d 209 (1986); R. Alta Charo, "Legislative Approaches to Surrogate Motherhood" (1988) 16:1-2 Law Med. Health Care 96 at 97.

It should be noted, however, that adoption laws in all provinces except Manitoba[311] are aimed solely at transactions intended to result in the adoption of a child. Any other transaction that does not constitute an adoption would therefore not be subject to these laws.

In the *Criminal Code* there are currently no provisions that specifically prohibit traffic in and the sale and purchase of children. On the other hand, the offences referred to in sections 279(1) (kidnapping), 279.1 (hostage taking), 280 (abduction of person under sixteen), 281 (abduction of person under fourteen), 282 (abduction in contravention of custody order) and 283 (abduction where no custody order) are not appropriate charges in all situations involving surrogate motherhood.[312]

B. Children

1. Legal Parentage

We have already outlined the problems the various technologies of medically assisted procreation pose for parentage law.[313] We must now consider the specific problem of the parentage of children born to a surrogate.

The parentage of a child born to a surrogate can depend on a number of factors, among them whether or not the woman voluntarily surrenders the child; whether the woman is married or single; and whether the surrogate provides the ovum or is only the gestational mother.[314]

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311. Unlike the other provinces, Manitoba does not limit the offence to adoption. Section 84 of *The Child and Family Services Act*, *supra*, note 309 reads as follows:

> Any person who gives or receives or agrees to give or to receive any payment or reward either directly or indirectly in consideration for
>
> (a) the purported sale of a child for any purpose; or
>
> (b) procuring or assisting in procuring the purported sale of a child for any purpose;
>
> is guilty of an offence punishable on summary conviction and liable to a fine of not less than $1,000.00 and not more than $10,000.00 or to imprisonment for a term not exceeding 6 months or both.

312. The Uniform Law Conference of Canada raised the various problems encountered by these provisions in the area of surrogate motherhood. See "Trafficking in Children" in Uniform Law Conference of Canada, *Proceedings of the Seventy-second Annual Meeting Held at Saint John, New Brunswick, August, 1990* (Fredericton, N.B.: The Conference, 1991) at 324.

313. *Supra* at 56ff.

314. See Jacqueline Rubellin-Devichi, "Les procréations assistées: état des questions" (1987) 86:3 Rev. trim. dr. civ. 457 at 489ff.

If an unmarried surrogate surrenders the child at birth, she will nevertheless be deemed to be the legal mother but she may also consent to adoption by the father's wife.[315] If she does not so consent, a motion may in theory be filed seeking deprivation of the surrogate's parental authority for having abandoned the child.

If an unmarried surrogate refuses to surrender the child, the social father, if he is also the child's biological father, may claim paternity.[316] He must also file an application for custody with the court, which will rule on the application according to the best interests of the child.[317]

If there is no dispute (the child is surrendered) but the surrogate is married, her husband is presumed to be the child's father.[318] The appropriate procedure is for the surrogate's

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315. See Rivet, *supra*, note 275 at 850-52. See also the recent decision in *Re Ontario Birth Registration Number 88-05-045846* (12 February 1990), Windsor A012/89 (Ont. Prov. Ct), wherein the judge approved the adoption of a child whose mother had been artificially inseminated with her father-in-law's sperm under a surrogacy agreement.

316. Dickens, *supra*, note 218 at 68:

> Some donors ... intend specifically to rear the children born to women who have acted as surrogate mothers. ... All these expectations, however, are subject to displacement, sometimes quite arbitrarily, by legislative provisions drafted with no regard for the different forms of artificial insemination and reproduction. The *Nova Scotia Family Maintenance Act*, for instance, defines a "possible father" as one who has "had sexual intercourse with ... the mother of a child," thereby excluding a donor for asexual reproduction.

See also art. 589 *C.C.Q.*

317. *Canadian Family Law Guide*, *supra*, note 274 at 2461: "The conflict between the common law principle of the *prima facie* right of a mother to the custody of her illegitimate child and the equitable principle that the welfare of the child is the paramount consideration is reflected in the case law relating to custody disputes between the parents of illegitimate children." See also at 2470, which quotes the decision in *D.(W.)* v. *P.(G.)*, [1984] 5 W.W.R. 289 (Alta C.A.):

> The traditional rule is that the natural father of a child born out of wedlock is a deemed stranger to the child. As such, he cannot wrest custody of the child from the mother without first demonstrating that she has either abandoned or neglected the child, or without offering other serious or commanding reasons. That is a court-made rule, however, and as such can be changed by the court.

318. Dickens, *supra*, note 218 at 69-70: "[A] sperm donor who seeks to establish his paternity may face legal obstacles, particularly if his object is to assert custody rights to a child born of a surrogate motherhood agreement made with a married woman." Knoppers and Sloss, *supra*, note 269 at 716: "Presumptions of paternity ... with respect to children born of artificial insemination would work against any biological father where the gestational mother was married or cohabiting with a man."

husband to disavow his paternity or for the surrogate herself to challenge her husband's paternity.[319] The biological father may then claim paternity.[320]

If a married surrogate refuses to surrender the child at birth, the social father will have to challenge the presumed paternity of the husband before it is confirmed by possession of status, in order to establish his own paternity through evidence that he is the biological father.

Even if the surrogate is not genetically linked to the child and there is a dispute, she will probably be deemed the legal mother. However, we may ask whether it would be possible for the genetic mother to challenge the gestational mother's maternity and file a claim of maternity on the grounds of her genetic link to the child.[321] Since the rule that establishes maternity by the fact of childbirth is not a substantive rule but a rule of

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319. In Quebec, see art. 581 *C.C.Q.*, subject to application of the defences at bar in art. 586 *C.C.Q.* to medically assisted procreation technologies other than artificial insemination. Note that art. 580 of Bill 125, *supra*, note 196, eliminates this ambiguity. For the Yukon and Newfoundland, see *supra*, note 277. See Knoppers, *supra*, note 284 at 220. Since, in the common law provinces, the presumption of paternity is rebuttable, a challenge to paternity may be made provided the evidence is sufficiently clear and convincing. Accordingly, the *Canadian Family Law Guide*, *supra*, note 274 at 2401, para. 4305, states:

> It is a strong presumption in law that children born in wedlock are in fact the legitimate offspring of the husband and wife. Where the husband had opportunity of access, a mere denial of paternity is not enough to rebut the presumption (*Re Johnston and Johnston* (1975), 10 O.R. (2d) 249 (Prov. Ct); *Guevara* v. *Guevara* (1976), 28 R.F.L. 30 (Man. Q.B.)); nor is an admission of paternity by another (*Re Brown and Argue*, [1925] 3 D.L.R. 873 (Ont. C.A.); *Re Anderson*, [1947] 3 D.L.R. 302 (N.B.C.A.)). Admission of paternity by another, however, when coupled with a temporary assumption of the child's support and cohabitation with the mother, was found to be enough to rebut the presumption in *Gray* v. *Foster* (1974), 19 R.F.L. 12 (Ont. Prov. Ct).

See also *B.(B.J.)* v. *K.(J.)*, *supra*, note 274 at 151:

> The presumption may be rebutted by evidence which satisfies the court, on the balance of probabilities, that the child's mother and her husband did not engage in sexual intercourse by which the child could have been conceived. The H.L.A. tissue typing test results should be taken into account, together with all the other relevant evidence, in determining whether the respondent has met the onus placed upon him. The weight given to the test results depends on the credibility of the parties.

320. For Quebec, see art. 589 *C.C.Q.* For the common law provinces, see Dickens, *supra*, note 279 at 355:

> In a surrogate motherhood transaction involving a married woman, her husband's name might have to be recorded as father of the child, leaving the intended father to seek a separate judicial declaration of paternity before he could gain a right of custody. He might also have to adopt his child before a birth certificate could be issued naming him as his child's father.

Dickens, *supra*, note 218 at 70: "In contrast to an ovum donor, a man entering an agreement and donating his sperm for the insemination will in law be entitled to recognition as father of the child."

321. See Martine Nolin and Héleine Guay, "Le phénomène des femmes porteuses: le droit à l'écoute de la science et de la société" in Martine Nolin, *Réflexions juridiques sur le phénomène des femmes porteuses d'enfants* (Cowansville, Que.: Yvon Blais, 1986) at 54; see also Rubellin-Devichi, *supra*, note 314 at 488.

evidence[322] — it does not appear in any legislation — and by analogy with the establishment of paternity,[323] some analysts claim that it would be possible to rebut the presumption of maternity on the basis of genetic filiation.[324]

In any event, it is clear from this brief review of the various issues that the current rules are inadequate.[325]

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322. Monique Bandrac, "Réflexions sur la maternité" in *Mélanges offerts à Pierre Raynaud* (Paris: Dalloz-Sirey, 1985) 27 at 30: [TRANSLATION] "While the result is surely that evidence of childbirth is enough to establish maternity, the fact of delivery is by no means the very essence of the link, and one could not seriously argue that the authors of the *Code civil* intended to settle, through the evidentiary scheme they established, a substantive problem of which they did not have the faintest idea."

323. *Ibid.* at 30-31:

> [TRANSLATION]
> It springs from the need imposed on the interpreter to adopt in respect of the father and the mother the same notion of the biological element whose role is today predominant in the components of blood parentage. . . . The basis for paternity then lies in heredity, and it seems that it is heredity as well, that is, the furnishing of a root cell, which forms the primary biological foundation of maternal parentage.

324. Knoppers and Sloss, *supra*, note 269 at 716:

> If the gestational mother refused to surrender custody the law would presume her right to the child as its gestational mother subject to later proof of paternity. If the child was actually the result of *in vitro* fertilization utilizing the sperm and ovum of the social parents, the societal parents would have recourse against her only in so far as they could prove their genetic link to the child.

However, this situation is subject to unchallengeable presumptions of paternity in cases where artificial insemination is used, if these provisions apply to gestational surrogate mothers; see *supra*, note 277. Faced with the division of the biological and gestational aspects of motherhood, a Michigan court recognized the right of the genetic parents to have their names on the birth certificate and to be deemed the legal parents. *Smith* v. *Jones* (14 March 1986), Michigan 8553201460 Wayne Co. Cir. Ct, in Sherrill Cohen and Nadine Taub, eds, *Reproductive Laws for the 1990s* (Clifton, N.J.: Humana, 1989) at 383. In a recent U.S. decision we find the following comment:

> [A] surrogate mother has lost her bid to be named the third parent of a test-tube baby she bore for an infertile couple.
>
> Judge Richard Parslow of the U.S. Superior Court [*sic*] ruled . . . that Anna Johnson does not have any parental rights to the baby boy born a month ago, and he granted permanent custody to Mark and Crispina Calvert, the couple who paid Ms Johnson $10,000 (U.S.) to carry their fertilized embryo. . . .
>
> Despite her contribution, the judge said, 'a surrogate carrying a genetic child for a couple does not acquire parental rights.'

Murray Campbell, "Woman Loses Bid to Be Parent" *The* [*Toronto*] *Globe and Mail* (23 October 1990) A-14. On appeal, the decision was affirmed: see *Anna J.* v. *Mark C.*, 286 Cal. Rptr. 369 (1991).

325. The Uniform Law Conference of Canada, in *An Act to amend the Uniform Child Status Act*, *supra*, note 199, proposes the following amendments:

> 11.3. A woman who gives birth to a child before or after the coming into force of this section is deemed to be the mother of the child whether or not the child is conceived using the woman's egg.
>
> . . .
>
> 11.4(1) A woman whose egg is used in an assisted conception and who does not give birth to the child conceived using her egg is deemed not to be the mother of the child.

2. Custody

From parentage stems parental authority,[326] and parental authority is the basis for custody. In medically assisted procreation, if parentage is established as vesting in the surrogate and her husband, they will have custody of the child unless they are deprived of their parental authority[327] and/or unless the interests of the child prevent them from retaining custody.[328]

On the other hand, if legal parentage is established as vesting in the surrogate and the social father, it may be difficult to determine custody of the child. The criterion then is the best interests of the child,[329] as determined in light of the circumstances in each case.[330]

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326. D.-Castelli, *supra*, note 271 at 182.

327. To deprive a person of parental authority, it must first be demonstrated that the holder of such authority "has been guilty, by action or inaction, of a serious and unjustified failure to perform the parental duty" (*C. (G.)* v. *V.-F. (T.)*, [1987] 2 S.C.R. 244 at 246). Further, such deprivation must be in the interest of the child (see art. 654 *C.C.Q.* and art. 606 of Bill 125, *supra*, note 196). See also Dickens, *supra*, note 218 at 71-72.

328. With respect to the common law, see Dickens, *supra*, note 218 at 52:

> In most cases ... the State's role is now seen to be to pursue the individual child's best interests, established by legal process. In the conflict between the ... two principles [the "natural rights" of the parents and the best interests of the child], it seems to be accepted, in Canada and elsewhere in the common law world, that the "best interests of the child" principle has prevailed.

See also M. Joyce Schlosser, "Third Party Child-Centred Disputes: Parental Rights v. Best Interest of the Child" (1984) 22 Alta L. Rev. 394 at 398 and 401. With respect to the civil law, see D.-Castelli, *supra*, note 271 at 185; the author refers to the Supreme Court decision in *C. (G.)* v. *V.-F. (T.)*, *supra*, note 327, in which the interest of the child was affirmed as a primary consideration. In the ruling, custody was awarded to third parties, taking into account the interest of the children without deprivation of parental authority or loss of custody rights. Beetz J. at 266-67: "In such a situation, the holder is deprived of the exercise of custody but not of the right itself."

329. D.-Castelli, *supra*, note 271 at 186. See art. 30 *C.C.L.C.* and arts 33 and 34 of Bill 125, *supra*, note 196. See also *Divorce Act, 1985*, S.C. 1986, c. 4. For the determination of the interests of the child, see *ibid.* ss 16(8) and (10) and 17(9). See Dickens, *supra*, note 218 at 72. Dickens refers to the following observation by Dubin J. in *Re Moores and Feldstein* (1973), 38 D.L.R. (3d) 641 at 647 (Ont. C.A.): "I do not think it safe to proceed on the assumption that a child will receive greater love and a more understanding upbringing if it is returned to a mother who did not want it at the time of its birth, than it would if left in the hands of those who sought it out for their love and care." Professor Dickens comments:

> Similarly, it would be perverse, and possibly harmful to the child's best interests, to place the child with strangers, when the father had not been shown to have violated legally mandated minimum standards of child protection. ... In Ontario ... section 55(1) of the Family Law Reform Act, [now section 56 of the *Family Law Act, 1986*, *supra*, note 196] provides that: "In the determination of any matter respecting ... custody of or access to a child, the court may disregard any provision of a domestic contract pertaining thereto where, in the opinion of the court, to do so is in the best interests of the child." This provision embodies the position at common law, and is applicable in principle to disputed custody of a child born in a surrogacy agreement.

In *Clark* v. *Clark* (1952), O.W.N. 671 at 671-72 (H.C.), Barlow J. stated this position thus: "The agreement as to custody is not binding on the Court if the Court in its discretion is of the opinion that it is not in the best interests of the child's physical, moral, emotional and spiritual welfare." See also the OLRC report, *supra*, note 2 at 96-97; and the U.S. decision in *Baby M*, *supra*, note 302.

330. See Dickens, *supra*, note 218 at 53: "[T]he concept of 'best interests' has become interpreted to mean the 'least detrimental alternative'."

The parent who is not granted custody nevertheless retains parental authority, but the ability to exercise that authority may be reduced to a simple right of supervision.[331] The parent without custody may also enjoy access rights, but such rights are neither automatic nor guaranteed.

There are two options open to lawmakers: either to resolve the custody problem by giving legal effect to the private agreement between the surrogate and the prospective parents, or to let the dispute be resolved according to the interests of the child.

In summary, the problematic issues here are the contractual and commercial aspects of surrogate motherhood, and the parentage and custody of the resulting child. We will return to these issues in our chapter of recommendations.

III. The *Canadian Charter of Rights and Freedoms*

To complete our study of the different legal questions raised by medically assisted procreation, we will examine the impact that the *Canadian Charter of Rights and Freedoms* is likely to have on any attempt by the government to regulate the use of and access to reproductive technologies.[332]

We will first examine whether a right to procreate is entailed in the right to liberty and security of the person enshrined in section 7 of the *Charter*, and whether such a right would entail a right of access to in vitro fertilization, artificial insemination, or a right to enforce a surrogacy contract. We will then turn to section 15 of the *Charter*, and discuss the impact that equality rights are likely to have on possible attempts to limit access to reproductive technologies. We conclude with a brief discussion of section 1 of the *Charter*.

But first it is necessary to stress that, in the absence of legislative regulation or other government intervention, the issues raised by medically assisted procreation are not constitutional issues. Pursuant to section 32, the *Charter* applies "to the Parliament and government of Canada" and "to the legislature and government of each province": it does not apply directly to the activities of private individuals.[333] Accordingly, the activities of doctors, hospitals or other non-governmental individuals or entities are not subject to the *Charter* unless their practices or policies are dictated by the government.[334]

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331. See D.-Castelli, *supra*, note 271 at 190-91.

332. The question of the constitutional division of legislative powers relating to these issues will not be addressed here.

333. *RWDSU* v. *Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573.

334. See *McKinney* v. *University of Guelph*, [1990] 3 S.C.R. 229; *Harrison* v. *University of British Columbia*, [1990] 3 S.C.R. 251; *Douglas/Kwantlen Faculty Assn.* v. *Douglas College*, [1990] 3 S.C.R. 570; *Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483.

Thus, a decision by government to abstain from regulating reproductive technologies will not give rise to constitutional challenges.[335] On the other hand, a decision to regulate the use of and access to reproductive technologies will give rise to a number of potential *Charter* challenges. In particular, a legislative restriction on access to reproductive technologies may violate either section 7 or section 15 of the *Charter*.

A. Section 7: The Right to Life, Liberty and Security of the Person

Section 7 reads as follows:

> *Everyone* has the right to life, liberty and security of the person *and* the right not to be deprived thereof except in accordance with the principles of fundamental justice [emphasis added].

The "and" in the middle of the text (as well as the semi-colon used in the French version) suggests that the section could be read disjunctively to provide two rights, both a right to "life, liberty and security of the person" and a right "not to be deprived thereof except in accordance with the principles of fundamental justice." However, the courts have rejected this interpretation, finding that section 7 provides one right, a right not to be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice.[336] Thus, establishing a violation of section 7 involves a two-step process: first, an individual must establish that his or her right to life, liberty or security of the person has been violated,[337] and second, that the violation was not in accordance with the principles of fundamental justice.

The term "everyone" raises the question of whether the unborn are included and can thus claim the benefit of the right not to be deprived of life except in accordance with the principles of fundamental justice. If the unborn do have section 7 rights, or if they are "individuals" for the purposes of section 15, then the *Charter* could have an impact, for example, on the handling of embryos frozen for purposes of IVF.

Prior to the enactment of the *Charter*, Canadian law recognized the legal existence of a fetus only upon its subsequent live birth.[338] The courts that have addressed the issue

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335. Of course, actions by non-governmental individuals or entities restricting access to reproductive technologies could be the subject of complaints under provincial human rights codes if individuals are discriminated against on the grounds of sex, family status, marital status, or sexual orientation.

336. See *Singh* v. *Minister of Employment and Immigration*, [1985] 1 S.C.R. 177; *R.* v. *Jones*, [1986] 2 S.C.R. 284; *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30.

337. The case law has established that the three interests protected by s. 7 — life, liberty and security of the person — are independent interests each of which must be given independent meaning. See *Singh*, *supra*, note 336 at 204-05; *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, [1985] 2 S.C.R. 486 at 500; *Morgentaler*, *supra*, note 336 at 52.

338. See *Montreal Tramways Company* v. *Léveillé*, [1933] S.C.R. 456; *Duval* v. *Seguin* (1972), 26 D.L.R. (3d) 418 (Ont. H.C.); *Dehler* v. *Ottawa Civic Hospital* (1979), 25 O.R. (2d) 748 (H.C.), aff'd (1980) 29 O.R. (2d) 677 (C.A.), leave to appeal to S.C.C. refused, [1981] 1 S.C.R. viii; *Langlois* v. *Meunier*, [1973] C.S. 301.

under the *Charter* have followed the traditional common law position and held that the unborn do not have *Charter* rights.[339] This position is consistent with the law in the United States,[340] in England[341] and under the European *Convention for the Protection of Human Rights and Fundamental Freedoms*.[342] By contrast, the Irish Constitution explicitly protects the right to life of the unborn,[343] and courts in former West Germany have found that a fetus falls within the constitutional guarantee of the right to life.[344]

The Supreme Court recently declined to resolve this issue in *Borowski* v. *Canada (Attorney General)*,[345] holding that the issue was moot and that the appellant no longer had standing to pursue the action.[346] Notwithstanding this uncertainty, it seems unlikely that the traditional Anglo-Canadian position on the rights of the unborn will be reversed under the *Charter*.[347] Accordingly, we will proceed on the basis that the legal treatment of a fetus or embryo is not subject to constitutional constraints flowing from the constitutional status of the unborn.

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339. *Borowski* v. *Attorney-General for Canada* (1987), 39 D.L.R. (4th) 731 (Sask. C.A.); *Campbell* v. *Attorney-General of Ontario* (1987), 58 O.R. (2d) 209 (H.C.), aff'd (1987) 60 O.R. (2d) 617 (C.A.), leave to appeal to the Supreme Court refused, [1987] 1 S.C.R. vi. But see the recent decision of the Quebec Court of Appeal in *Daigle*, *supra*, note 219, in which the Court held, three to two, that a fetus has a right to life under the Quebec Charter, *supra*, note 255. However, this judgment was reversed by a unanimous decision of the Supreme Court of Canada.

340. See *Roe* v. *Wade*, 410 U.S. 113 at 161 (1973): "[T]he law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth." However, in a recent ruling, *Webster* v. *Reproductive Health Services*, 492 U.S. 490 at 518 and 526 (1989), a majority of the Court indicated that the decision in *Roe* may be overruled in the near future. Four judges subscribed to the view that *Roe* was "unsound in principle and unworkable in practice," and Justice O'Connor suggested that the Court should "reexamine Roe ... carefully" in a future case.

341. *Paton* v. *Trustees of BPAS*, [1978] 2 All E. R. 987 at 989 (Q.B.): "The foetus cannot, in English law, in my view, have any right of its own at least until it is born and has a separate existence from its mother."

342. Also known as *European Convention on Human Rights* (1955) 213 U.N.T.S. 221. See *Paton* v. *United Kingdom* (1980), 3 E.H.R.R. 408: a fetus does not have a right to life under art. 2 of the Convention, at least not in the initial stages of pregnancy.

343. Section 40.3.3, added to the Irish Constitution after a referendum in 1983, provides that: "The state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and as far as practicable, by its laws to defend and vindicate that right."

344. See the discussion in *Borowski* (1987), *supra*, note 339 at 747-48.

345. [1989] 1 S.C.R. 342.

346. The 1989 *Borowski* case, *supra*, note 345, began as a challenge to s. 251, the old therapeutic abortion provision of the *Criminal Code*. In January 1988, the Supreme Court released its decision in *Morgentaler*, *supra*, note 336, in which s. 251 was struck down as a violation of a woman's rights under s. 7 of the *Charter*. Thus, when the *Borowski* appeal was argued later in the year, the legal basis for the challenge no longer existed.

347. For a full discussion of the many legal and ethical difficulties that would follow from such a holding, see Catherine Tolton, "Medicolegal Implications of Constitutional Status for the Unborn: 'Ambulatory Chalices' or 'Priorities and Aspirations'" (1988) 47 U.T. Fac. L. Rev. 1.

1. The Right to Procreate

Is a right to procreate entailed in the right to life, liberty or security of the person? Surely, a person's life is not threatened by a denial of access to reproductive technologies. At the most, it is the possibility of creating a new life that is being denied to the person. Thus, an individual's "right to life" is not relevant here. However, it may be that the right to have access to the means to attempt procreation is an element of either the right to liberty or the right to security of the person.

The meaning of the "right to liberty" has yet to be clearly set out by the Supreme Court of Canada. At least we know that the phrase encompasses deprivations of physical liberty such as imprisonment.[348] Beyond instances of physical restraint, it is, as the Court has noted, a phrase "capable of a broad range of meaning."[349] Yet thus far only Justice Wilson has explored in her judgments the potential breadth of the "liberty" protected by section 7: the other justices have not yet found occasion to do so. For example, in *R.* v. *Jones*,[350] Justice La Forest was willing to assume that the right to liberty included a "right of parents to educate their children as they see fit," but he did not find it necessary to decide the issue.

Justice Wilson has articulated a definition of liberty that would entail a right to procreate. In her view,

> the right to liberty contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives.[351]

In *Jones*,[352] she held that the right to liberty protects the parents' right to raise their children in accordance with their conscientious beliefs. In *Morgentaler*,[353] she held that a woman's decision whether or not to terminate a pregnancy fell within the class of decisions protected from state interference by the right to liberty. Such a decision has "profound psychological, economic and social consequences for the pregnant woman."[354] Could we not say the same about the decision to bear and raise a child conceived with the assistance of a reproductive technology?

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348. See *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337.

349. See *Singh*, *supra*, note 336 at 206.

350. *Supra*, note 336 at 302.

351. See *Morgentaler*, *supra*, note 336 at 171. See also *Jones*, *supra*, note 336 at 318, where Justice Wilson offered the following rationale for the right to liberty:

> I believe that the framers of the Constitution in guaranteeing "liberty" as a fundamental value in a free and democratic society had in mind the freedom of the individual to develop and realize his potential to the full, to plan his own life to suit his own character, to make his own choices for good or ill, to be non-conformist, idiosyncratic and even eccentric — to be, in to-day's parlance, "his own person" and accountable as such.

352. *Supra*, note 336.

353. *Supra*, note 336.

354. *Ibid.* at 171.

In defining liberty, Justice Wilson relied heavily on a series of U.S. constitutional cases establishing an area of personal autonomy over reproductive decisions as an element of the constitutional guarantee of "liberty" in the due process clause of the Fourteenth Amendment. For example, in *Singh*[355] and *Jones*,[356] she relied on a passage in *Meyer* v. *Nebraska*[357] in which the United States Supreme Court stated that:

> [Liberty] denotes not merely freedom from bodily restraint but also the right of the individual ... to marry, establish a home and bring up children ... .[358]

And in *Morgentaler*,[359] Justice Wilson approved of the U.S. cases, discussed below, that established a right of access to contraception and abortion as an element of liberty protected by the Fourteenth Amendment. In sum, Justice Wilson's position is that liberty would be infringed by any state interference with an individual's access to the means to procreate. However, whether such a broad conception of liberty will garner the support of the majority of the Court remains to be seen.

The right to security of the person, like the right to liberty, is capable of a broad range of meaning.[360] The core meaning of the concept, in the words of then Chief Justice Dickson in *Morgentaler*, is that "the human body ought to be protected from interference by others."[361] In *Singh*, Justice Wilson stated that security of the person protects an individual from the threat of physical punishment or suffering as well as freedom from the actual punishment or suffering itself.[362] And the courts have indicated that security of the person extends to the control of one's psychological well-being as well as one's physical integrity.[363] As Justice Lamer argued in *Mills* v. *The Queen*:[364]

> [S]ecurity of the person is not restricted to physical integrity; rather, it encompasses protection against "overlong subjection to the vexations and vicissitudes of a pending criminal accusation." ... These include stigmatization of the accused, loss of privacy, stress and anxiety resulting from a multitude of factors, including possible disruption of family, social life and work, legal costs, uncertainty as to the outcome and sanction.[365]

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355. *Supra*, note 336 at 205.

356. *Supra*, note 336 at 317-18.

357. 262 U.S. 390 (1923).

358. *Ibid.* at 399.

359. *Supra*, note 336 at 167-71.

360. *Singh*, *supra*, note 336 at 206.

361. *Supra*, note 336 at 53.

362. *Supra*, note 336 at 207.

363. *R.* v. *Videoflicks Ltd* (1984), 48 O.R. (2d) 395 at 433 (C.A.).

364. [1986] 1 S.C.R. 863.

365. *Ibid.* at 919-20.

In *Morgentaler*, the five majority justices found that serious state-imposed psychological stress violated security of the person. Justice Beetz held that security of the person "include[s] a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction."[366] According to then Chief Justice Dickson,

> state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of security of the person. It is not necessary in this case to determine whether the right extends further, to protect either interests central to personal autonomy, such as a right to privacy, or interests unrelated to criminal justice.[367]

It is possible that the anxiety and stress caused to a person otherwise unable to procreate by the denial of access to reproductive technology could fall within the definition of security of the person offered by the justices in the *Morgentaler* case. However, as then Chief Justice Dickson noted, the psychological component of security of the person has yet to be applied by the Supreme Court outside the context of a criminal prosecution.

The Court has also yet to decide whether security of the person extends beyond the protection of physical or psychological integrity to a broader right of privacy or autonomy that might encompass the right to procreate and other rights related to family life. However, a number of lower courts have suggested that security of the person does entail a right of autonomy over personal and intimate decisions.[368]

Given the uncertainty regarding the meaning of "liberty" and "security of the person" in these early stages of *Charter* interpretation, it will be useful to consider the U.S. constitutional jurisprudence as it relates to the right to procreate. As we noted above, Justice Wilson found it useful in interpreting section 7 of the *Charter*, and in the absence of guiding Canadian precedent, U.S. case law will continue to be an influential source for *Charter* interpretation.

The United States Supreme Court first recognized the importance of procreative autonomy in *Skinner* v. *Oklahoma*, holding that forced sterilization of habitual criminals violated the equal protection clause.[369] Justice Douglas termed the right to have offspring "a sensitive and important area of human rights. ... a right which is basic to the perpetuation of a race."[370] Later in the opinion he added that:

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366. *Supra*, note 336 at 81.

367. *Ibid.* at 56.

368. See *Re T and Catholic Children's Aid Society* (1984), 46 O.R. (2d) 347 (Prov. Ct) (right to security of the person includes the right to individual privacy or family autonomy); *S.(S.)* v. *Director of Child and Family Services*, [1987] 5 W.W.R. 309 (Man. Q.B.) (same); *R.L. Crain Inc.* v. *Couture* (1983), 6 D.L.R. (4th) 478 at 502 (Sask. Q.B.): "[T]he phrase 'security of the person' includes a right to personal dignity and a right to an area of privacy or individual sovereignty into which the State must not make arbitrary or unjustified intrusions."

369. 316 U.S. 535 (1942).

370. *Ibid.* at 536.

> We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. . . . [The person sterilized by the state] is forever deprived of a basic liberty.[371]

Most of the U.S. cases protecting procreative autonomy have relied on the right to privacy guaranteed by the Fourteenth Amendment. Although the U.S. Constitution does not explicitly recognize a right of privacy, the Court has found that one aspect of "liberty" protected by the due process clause of the Fourteenth Amendment is "a right of personal privacy, or a guarantee of certain areas or zones of privacy."[372] This right to personal privacy includes "the interest in independence in making certain kinds of important decisions,"[373] such as the choice to make use of contraceptives to avoid procreation.[374] As Justice Brennan put it:

> If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.[375]

The Court has also recognized the rights to marry and to raise and educate children as fundamental rights under the Fourteenth Amendment.[376] Similarly, in 1973 the Supreme Court held that the right to privacy outlined in these cases was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[377] The Court has held, however, that the state may refuse to pay for abortions[378] even if they are medically necessary to preserve the mother's life or health,[379] and that the state may prohibit the performance of abortions by public employees or in public hospitals.[380]

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371. *Ibid.* at 541.

372. *Roe* v. *Wade*, *supra*, note 340 at 152.

373. *Whalen* v. *Roe*, 429 U.S. 589 at 599-600 (1977).

374. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965) (state cannot make the use of contraceptives by married persons a crime); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972) (invalidating a regulation which made contraceptives less available to the unmarried than to married couples); *Carey* v. *Population Services International*, 431 U.S. 678 (1977) (invalidating a state ban on the commercial distribution of non-medical contraceptives). See *Carey*, *ibid.* at 687: "Read in light of its progeny, the teaching of Griswold is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."

375. *Eisenstadt*, *supra*, note 374 at 453.

376. *Loving* v. *Virginia*, 388 U.S. 1 (1967) (race may not be a basis for restricting an individual's right to marry); *Zablocki* v. *Redhail*, 434 U.S. 374 (1978) (striking down a statute requiring a certain class of state residents to obtain court permission to marry); *Meyer*, *supra*, note 357 at 399 (recognizing a constitutional right to "marry, establish a home and bring up children"); *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925) (child rearing and education).

377. *Roe* v. *Wade*, *supra*, note 340 at 170. See also *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52 (1976); *Akron (City of)* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

378. *Maher* v. *Roe*, 432 U.S. 464 (1977).

379. *Harris* v. *McRae*, 448 U.S. 297 (1980).

380. *Webster*, *supra*, note 340.

The right to privacy in U.S. constitutional law thus protects the individual from state interference with his or her procreative potential. In addition, an individual has the right to be free from state interference with his or her access to the means of contraception. However, the state has no obligation to provide the individual with resources adequate to ensure access to the means of contraception.

Courts in the United States have not yet resolved the issue of whether the right to privacy includes the right to have access to existing reproductive technology free from state interference. A number of authors have argued that the right to privacy entails the right to unrestricted access to the means to attempt to conceive, John Robertson being the most forceful advocate of this position.[381] In his view, any state regulation of access to reproductive technologies must be justified by a compelling state purpose: "the state must carry the burden of showing actual harm from [the] use of these techniques."[382] But, as Knoppers observes, the ultimate judicial recognition of a constitutional right to procreate by whatever means available as an expression of personal liberty or privacy is uncertain,[383] particularly in light of the current Supreme Court's reluctance to expand this branch of substantive due process.[384]

If uncertainty on these issues reigns under the U.S. Constitution, this is all the more true in Canada, where *Charter* jurisprudence is still in its early stages. In only one case thus far has a Canadian court faced an argument that a right to procreate is included in section 7. In *E. (Mrs.)* v. *Eve*,[385] the Supreme Court considered whether a court had the power, under its *parens patriae* jurisdiction, to authorize the non-therapeutic sterilization of a mentally handicapped woman. The Court concluded as follows:

> The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.[386]

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381. See John A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth" (1983) 69 Va. L. Rev. 405; "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction" (1986) 59 S. Cal. L. Rev. 939; "Decisional Authority over Embryos and Control of IVF Technology" (1988) 28:3 Jurimetrics 285. See also Barbara Kritchevsky, "The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family" (1981) 4 Harv. Women's L.J. 1; Andrea E. Stumpf, "Redefining Mother: A Legal Matrix for New Reproductive Technologies" (1986) 96 Yale L.J. 187.

382. John A. Robertson, "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction" (1988) 16:1-2 Law Med. Health Care 18 at 24.

383. Knoppers, *supra*, note 221 at 348-49.

384. See *Bowers* v. *Hardwick*, 478 U.S. 186 (1986).

385. [1986] 2 S.C.R. 388.

386. *Ibid.* at 431.

Relying on U.S. precedent, counsel for the party seeking the sterilization argued before the Court that section 7 entailed a right to free procreative choice, including a right to choose to have or not to have children and to implement that choice by means of contraception.[387] Justice La Forest, speaking for the Court, did not find it necessary to decide this point:

> [A]ssuming for the moment that liberty as used in s. 7 protects rights of this kind (a matter I refrain from entering into), counsel's contention seems to me to go beyond the kind of protection s. 7 was intended to afford. All s. 7 does is give a remedy to protect individuals against laws or other state action that deprive them of liberty. It has no application here.[388]

Although the Court did not find it necessary to rely on the *Charter* in deciding the case, it emphasized the fundamental nature of the right to procreate. Justice La Forest pointed out the "growing legal recognition of the fundamental character of the right to procreate,"[389] "the great privilege of giving birth"[390] and "[t]he importance of maintaining the physical integrity of a human being . . . particularly as it affects the privilege of giving life."[391] He characterized the proposed sterilization as a "grave intrusion on a person's rights"[392] and an "irreversible and serious intrusion on the basic rights of the individual."[393]

In conclusion, Canadian courts have not yet addressed the question of whether the right to liberty and the right to security of the person guaranteed by section 7 entail a right to procreate. However, in light of the expansive definition of liberty advanced by Justice Wilson, the influence of U.S. jurisprudence, and the strong language of Justice La Forest in the *Eve* case underlying the importance to an individual of the ability to procreate, it seems likely that either liberty or security of the person, or both, will be found in a future case to include the right to procreate.

2. The Deprivation of Liberty or Security of the Person and the Principles of Fundamental Justice

As noted above, establishing a violation of section 7 involves a two-step process. First, one must establish that there has been an interference with life, liberty or security of the person and, second, one must show that the interference is not in accordance with the

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387. *Ibid.* at 436.

388. *Ibid.*

389. *Ibid.* at 419-20.

390. *Ibid.* at 428.

391. *Ibid.* at 434.

392. *Ibid.* at 431.

393. *Ibid.* at 432. The English courts reached the same conclusion in a case involving a fact situation similar to that in *Eve*. In *Re D (a minor)*, [1976] 1 All E. R. 326 at 332, the Court stated:

> The type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce, and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right.

principles of fundamental justice. Assuming that the courts do hold that the right to liberty or security of the person entails a right to procreate, legislation limiting access to reproductive technologies will not necessarily violate section 7. That will only be the case if the legislative limits are imposed in a manner that violates the principles of fundamental justice.

The principles of fundamental justice have both a procedural and a substantive component.[394] In their procedural aspect, the principles of fundamental justice are similar to common law notions of procedural fairness. As Justice Wilson put it in *Singh*, procedural fairness means that:

> [T]he tribunal which adjudicates upon [a person's] rights must act fairly, in good faith, without bias and in a judicial temper, and must give to him the opportunity to adequately state his case.[395]

This means that persons seeking to exercise their right to procreate through the use of a reproductive technology must be treated in a procedurally fair manner by any law limiting access to that technology. The operation of the administrative structure must not be unfair or arbitrary,[396] and the criteria determining accessibility must not be vague.[397] An applicant who is initially denied access must be granted an opportunity to defend his or her rights.[398] The applicant must be made aware of the reasons for the denial of access prior to the hearing, and at the hearing the applicant must be given an adequate opportunity to state his or her case. It should be noted, however, that an oral hearing will not be necessary in cases in which credibility is not at issue. As Justice Wilson stated in *Singh*:

> I am prepared to accept [the] submission that procedural fairness may mean different things in different contexts. . . . Thus it is possible that an oral hearing before the decision-maker is not required in every case in which s. 7 of the *Charter* is called into play. . . .
>
> I should note, however, that even if hearings based on written submissions are consistent with the principles of fundamental justice for some purposes, they will not be satisfactory for all purposes. In particular, I am of the view that where a serious issue of credibility is involved, fundamental justice requires that credibility be determined on the basis of an oral hearing.[399]

According to the Supreme Court, the substantive aspects of the principles of fundamental justice

> are to be found in the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system.[400]

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394. *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337 at 497-99.

395. *Supra*, note 336 at 213, quoting *Duke* v. *The Queen*, [1972] S.C.R. 917 at 923.

396. See *Morgentaler*, *supra*, note 336.

397. *Ibid.*

398. See *Singh*, *supra*, note 336.

399. *Ibid.* at 213-14.

400. *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337 at 503.

An example of such a principle is the notion that the morally innocent shall not be punished; any law that has the potential of depriving the morally innocent of their liberty will accordingly violate section 7.[401]

The substantive aspects of the principles of fundamental justice enable the courts to go beyond the examination of the fairness of the administration of the law to an evaluation of the substance of the legislation to determine whether it complies with "the basic tenets of our legal system." This appears to require the courts to pass judgment on the wisdom of a legislative policy that interferes with life, liberty or security of the person, a task that courts prefer to leave to the legislature. Accordingly, this is a branch of section 7 review that the courts are likely to apply with some caution.[402] Thus far the Court has not developed any substantive principles of fundamental justice outside the context of criminal procedure.

As long as any restrictions on access to reproductive technologies are not arbitrary,[403] it is unlikely that such restrictions would conflict with substantive principles of fundamental justice. The Court has stated that the future growth of the principles of fundamental justice will be based on "historical roots"[404] that "have been developed over time as presumptions of the common law" or "have found expression in the international conventions on human rights" or "have been recognized as essential elements of a system for the administration of justice which is founded upon a belief in 'the dignity and worth of the human person' and on 'the rule of law'."[405] An unrestricted right of access to the means necessary to procreate does not have such privileged roots in our legal traditions.

B. The Application of Section 7 to Certain Aspects of Medically Assisted Procreation

In light of the above general discussion of the principles governing the interpretation of section 7, we will now turn to the more specific issues raised by surrogate motherhood and access to medically assisted procreation.

1. The Enforceability of Surrogacy Contracts

In this section we will consider whether legislation rendering surrogacy contracts enforceable or unenforceable, or regulating the circumstances in which such contracts would be enforceable in court, would interfere with rights protected by section 7 of the *Charter*.

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401. *Ibid.*; *R.* v. *Vaillancourt*, [1987] 2 S.C.R. 636.

402. See the comments of Dickson C.J. in *Morgentaler*, *supra*, note 336 at 53.

403. See, *e.g.*, *R.* v. *Beare*; *R.* v. *Higgins*, [1988] 2 S.C.R. 387.

404. *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337 at 513.

405. *Ibid.* at 503.

The only case that discusses the relationship between a constitutional right to procreate and the enforceability of surrogacy contracts is the U.S. case of *Baby M*,[406] which arose out of the competing claims of the biological mother and father in a dispute over the custody of a child conceived in performance of a surrogacy contract. The biological father, Mr. Stern, argued that the right to procreate included the right to enforce a surrogacy contract. In holding that he had a constitutional right to custody of the child, the lower court reasoned as follows:

> [I]f one has a right to procreate coitally, then one has the right to reproduce non-coitally. If it is the reproduction that is protected, then the means of reproduction are also to be protected. The values and interests underlying the creation of family are the same by whatever means obtained. This court holds that the protected means extends to the use of surrogates. ... It might even be argued that refusal to enforce these contracts and prohibition of money payments would constitute an unconstitutional interference with procreative liberty since it would prevent childless couples from obtaining the means with which to have families. ... A woman and her husband have the right to procreate and rear a family. The means to do so can be withheld from them only on a showing of a compelling state interest.[407]

The Court therefore held that the rights of the parties under the surrogate contract were constitutionally protected. On appeal, the New Jersey Supreme Court rejected this reasoning, holding that:

> The right to procreate very simply is the right to have natural children, whether through sexual intercourse or artificial insemination. It is no more than that. Mr. Stern has not been deprived of that right. ... The custody, care, companionship, and nurturing that follow birth are not parts of the right to procreation. ... To assert that Mr. Stern's right of procreation gives him the right to the custody of Baby M would be to assert that Mrs. Whitehead's right of procreation does *not* give her the right to the custody of Baby M; it would be to assert that the constitutional right of procreation includes within it a constitutionally protected contractual right to destroy someone else's right of procreation. ... There is nothing in our culture or society that even begins to suggest a fundamental right on the part of the father to the custody of the child as part of his right to procreate when opposed by the claim of the mother to the same child.[408]

The *Baby M* decision is in accord with the earlier case of *Doe* v. *Kelley*,[409] a challenge to a Michigan adoption statute that prohibited the exchange of money or other consideration in connection with an adoption or related proceedings. A couple sought to engage in a surrogacy arrangement and to rely on an adoption proceeding to secure their legal right to the child. The court found that the statute did not violate the couple's right to procreate:

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406. 525 A. 2d 1128 (N.J. Super. Ch. 1987).

407. *Ibid.* at 1164-65. See the criticisms of this reasoning in Laurence A. Tribe, *American Constitutional Law*, 2d ed. (Mineola, N.Y.: Foundation, 1988) at 1360-62.

408. *Baby M*, *supra*, note 302 at 1253-54. See the criticism in Robertson, *supra*, note 382 at 23-24.

409. *Supra*, note 310.

> The statute in question does not directly prohibit John Doe and Mary Roe from having the child as planned. It acts instead to preclude plaintiffs from paying consideration in conjunction with their use of the state's adoption procedures. In effect, the plaintiffs' contractual agreement discloses a desire to use the adoption code to change the legal status of the child — *i.e.*, its right to support, intestate succession, etc. We do not perceive this goal as within the realm of fundamental interests protected by the right to privacy from reasonable government regulation.[410]

Robertson has disputed these courts' claim that the right to procreate does not "includ[e] within it a constitutionally protected contractual right to destroy someone else's right of procreation."[411] He argues that the parties to a surrogacy arrangement should have the freedom of contract to dispose of their constitutional rights as they see fit:

> A strong argument based on the autonomy of couples and surrogates can be made that the preconception agreement of the parties, which made the very existence of the child possible, should prima facie be determinative, just as it would be with sperm or egg donors. . . . It simply is unclear why [the] agreement, if knowingly and freely made, should not control in [the] circumstances.[412]

In the Canadian context, the argument that the biological father has a right under section 7 of the *Charter* to enforce a surrogacy contract depends on a number of problematic propositions: first, that the right to procreate entails custody rights once the child is born; second, that denying the father custody of the child would violate the principles of fundamental justice; and, finally, that the biological mother is free to contractually waive her own constitutional right to procreate (to the extent that it too would entail a right to custody of the child) and that she is not free to revoke that waiver when the child is born.

On the other hand, a biological mother's claim to a constitutional right to retain custody of the child conceived in performance of a surrogacy agreement would also depend upon the assertion of a number of problematic propositions: first, that the right to procreate entails a right to custody once the child is born; second, that denying her custody of the child would violate the principles of fundamental justice; and, finally, that a pre-conception contractual agreement to turn over the child is an ineffective waiver of her constitutional rights.

As far as the right to custody is concerned, an argument can be made that the right to procreate is an empty one if the state permits a child to be taken from its parents at birth.[413] However, there are obvious difficulties in superimposing a constitutional framework on the competing claims made by parties to custody disputes. Our law gives primacy to the best interests of the child rather than to the alleged *Charter* rights of the parents.

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410. *Ibid.* at 441.

411. Robertson, *supra*, note 382 at 23; see also *Baby M*, *supra*, note 302 at 1254.

412. Robertson, *supra*, note 382 at 23-24.

413. *Ibid.* at 23: "[R]earing [is] the result that makes conception itself so worthy of protection. . . . Mr. Stern's interest in hiring a surrogate is precisely to conceive a child whom he will then rear."

It is not surprising that courts have been reluctant to allow the *Charter* to add further procedural complexity to child-protection and custody disputes.[414]

Even assuming the biological parents could each assert a constitutional right to custody, we would nonetheless be left with reciprocal, competing constitutional claims, as in the *Baby M* case.[415] It has been argued that the way out of this deadlock is to allow the contractual determination of rights to prevail: the biological father's constitutional claim would prevail because the biological mother waived her constitutional rights when she entered into the surrogacy agreement.[416]

The Supreme Court of Canada has in fact held that individuals are free to waive their constitutional rights.[417] The Court has stated that an individual "cannot be compelled to take advantage of rights for his or her benefit even if such rights may have a public interest aspect."[418] To be effective, however, any waiver of rights must be voluntary, and it "must be premised on a true appreciation of the consequences of giving up the right."[419] On this test, the question is whether a biological mother, at the time of entering into a surrogacy contract, could ever have a "true appreciation" of the emotional difficulty she might experience in surrendering the child to the biological father. Another difficulty is that a biological mother seeking to retain custody of the child is clearly no longer *freely* waiving her alleged constitutional rights. It is not clear that a waiver of constitutional rights would be effective if it is subsequently revoked in these circumstances.

At present, surrogacy contracts are probably unenforceable in civil and at common law as being contrary to public policy,[420] although the issue has yet to be tested in a Canadian court. Recent legislation in England has rendered surrogacy arrangements unenforceable and prohibited all commercial agreements,[421] a development in line with the recommendations of most of the studies carried out in this area.[422] As Knoppers and Sloss have pointed out:

> These recommendations are based on the negative psychological and emotional implications for the gestational mother on having to give up a child she carried to term, the repugnance of contracting to surrender parental rights, and the potential of commercial exploitation of such arrangements (which one British report has equated with prostitution).[423]

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414. See *Re T and Catholic Children's Aid Society*, *supra*, note 368; *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4th) 394 (Alta Q.B.).

415. *Supra*, note 302.

416. See Robertson, *supra*, note 382.

417. See *Clarkson* v. *The Queen*, [1986] 1 S.C.R. 383 at 396 (right to counsel cannot be forced upon an unwilling accused); *R.* v. *Turpin*, [1989] 1 S.C.R. 1296 (waiver of right to a jury trial).

418. *Turpin*, *supra*, note 417 at 1316.

419. *Clarkson*, *supra*, note 417 at 396.

420. See "Legality and Legitimacy," *supra* at 65.

421. See the *Human Fertilisation and Embryology Act 1990* (U.K.), 1990, c. 37, s. 36, and the *Surrogacy Arrangements Act 1985* (U.K.), 1985, c. 49, s. 2, following the recommendations of the *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (London: HMSO, 1984) at 47 (Chair: Dame Mary Warnock) [hereinafter Warnock Report].

422. For more details, see appendix A, *infra* at 173.

423. *Supra*, note 269 at 709.

If legislation were passed to make clear that surrogacy contracts were legally unenforceable, it is unlikely that the courts would find a violation of section 7 of the *Charter*. Even assuming that any such legislation would be found to constitute an interference with liberty because of the burden on the right to procreate of men with infertile partners, and assuming also that the courts would hold that the biological mother is free to contractually waive her constitutional rights, restrictions on conception arrangements involving a consideration would not violate the principles of fundamental justice.

Rendering surrogacy contracts unenforceable is consistent with two fundamental principles of existing family law. The first is that custody of children be determined in accordance with the best interests of the child rather than the contractually expressed wishes of the parents. The primacy placed on the best interests of the child over freedom of contract is evident in family law legislation that prohibits parties from dealing with custody or access to children in marriage contracts or cohabitation agreements,[424] and that empowers a court to disregard any provision of a domestic contract pertaining to the support, education, moral training, custody of or access to a child if it is in the best interests of the child to do so.[425] Second, it is illegal to receive payment in return for arranging the adoption of a child.[426] Such legislation, far from violating the fundamental tenets of the Canadian legal system, is consistent with those tenets.

In summary, there are many legal obstacles in the way of the argument that custody disputes following the birth of a child to a surrogate can be resolved by recourse to section 7 of the *Charter*. It seems likely that any legislation passed in this area, whether it renders surrogacy contracts enforceable or unenforceable, will not offend the section 7 rights of either biological parent.

2. In Vitro Fertilization

The theory that the right to procreate entails a right of access to IVF technology was argued before a U.S. federal court, but the judgment left the issue unresolved. In *Smith* v. *Hartigan*,[427] an infertile couple alleged that an Illinois statute rendered in vitro fertilization illegal and thus "infringe[d] on their privacy interests because the provision prevent[ed] them from effectuating their only hope for conceiving a child."[428] While the defendant attorney general conceded that the "plaintiffs' situation presents the strongest case for a fundamental right to [in vitro fertilization],"[429] the court found it unnecessary to address the constitutional issue, it having held that the statute did not prohibit in vitro fertilization in the circumstances.

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424. See, *e.g.*, ss 52(1)(c) and 53(1)(c) of the Ontario *Family Law Act, 1986*, *supra*, note 196.

425. *Ibid.*, s. 56(1).

426. See *supra* at 67ff.

427. 556 F. Supp. 157 (1983).

428. *Ibid.* at 160.

429. *Ibid.* at 161.

It is not possible to predict whether a Canadian court would interpret the right to procreate to include access to IVF services. It may be that the right to procreate will be limited to natural procreation only, or extended no further than to include artificial insemination. Nevertheless, the prudent course would appear to be to assume that access to IVF might be held to fall within the scope of section 7 of the *Charter*.

Even were a court to so conclude, it would not mean that access to IVF could not be limited or regulated. Canadian case law suggests that the guarantee of *Charter* rights and freedoms does not impose affirmative obligations on governments to initiate laws or programs, because prior government action is necessary to invoke the *Charter*.[430] Thus, the government has no obligation to initiate the provision of IVF services. But were the government to pass legislation restricting access to existing IVF services, then the necessary government action would be present and the right to procreate of infertile women and their partners could be found by a court to have been violated. If so, any such legislative restriction would have to be in accordance with the principles of fundamental justice.

It is difficult to predict what procedures a court would require to comply with the principles of fundamental justice in such a case. At the very least, fundamental justice would require that access to IVF services be determined in accordance with fair and rational criteria that are communicated to applicants. Furthermore, fundamental justice would require that applicants for IVF services be treated in a procedurally fair manner, and given an opportunity to present their case fully in their application for access. It is unlikely that a court would insist that there be an oral hearing at this stage, as long as the criteria are clear and no issues of credibility are raised.[431] It is even more difficult to predict whether in this context fundamental justice would require that there be a system of appeal from decisions denying access to IVF services.[432]

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430. See, *e.g.*, *RWDSU* v. *Dolphin Delivery Ltd.*, *supra*, note 333. However, where government has initiated a program on a limited basis, a remedy can be obtained under the *Charter* ordering the extension of benefits or services in a manner consistent with s. 15 equality rights. See, *e.g.*, *Schachter* v. *Canada*, *infra*, note 564.

    Some sections of the *Charter*, such as the language rights in ss 16-23, do expressly create entitlements to a particular government service and may thus be invoked in the absence of government action; however, those sections are not relevant to the present discussion of the right to procreate.

431. See *Singh*, *supra*, note 336.

432. *Ibid.* In *Singh*, where the threat to liberty arose from the possibility of persecution (or even death) on the return of refugee applicants to their home country, the Supreme Court stated that fundamental justice required that a right of appeal be granted. In our view, the degree of interference with the liberty interest of an applicant for IVF services is not as extensive as was the case in *Singh*. Since the procedural protection required by s. 7 will vary with the degree of interference with the liberty interest, it may well be that a court would find an appeal right unnecessary in this context.

3. Artificial Insemination (AI)

The only reported cases dealing with AI involve the issue of the child's parentage.[433] In the only constitutional challenge to a possible restriction of AI to exclude single women, the Michigan chapter of the American Civil Liberties Union filed a complaint on behalf of a single woman who was refused AI, but the case was settled when the clinic accepted the woman's application.[434]

AI is unlike IVF in that minimal or non-existent technological requirements, public expense or medical complications are involved. The procedure can be performed very simply in the privacy of one's home without the intervention of experts. And unlike surrogacy, the involvement of the genetic donor is not an ongoing one: the genetic donor's involvement in the process is often over once he has made his contribution of semen. For these reasons, attempts to regulate the performance of AI raise serious privacy concerns that are not present with the other techniques of non-coital procreation. Just as regulation "is neither desirable nor practicable in the case of natural reproduction,"[435] it may be argued that the state has no place in the bedroom of a woman attempting to artificially inseminate herself. Regulation of such private behaviour would constitute an interference with liberty and might, it may be argued, infringe the principles of fundamental justice. A basic tenet of our legal system is the principle of non-interference in private behaviour that causes no harm to others.

Regulation of sperm banks or of the medical performance of AI does not raise such privacy concerns. The purpose of such regulation would be to ensure that genetic and other health problems are avoided. Ensuring the safety of the AI procedure in this way would not raise constitutional objections.

4. The Right to Be Informed of One's Biological Origins

The issue to be addressed in this section is whether a child conceived by means of medically assisted procreation has a constitutional right to information regarding his or her genetic origins.

The psychological need to know one's biological roots has gained increasing recognition in the context of adoption, and a growing number of adoptees have been pressuring courts and legislatures to relax the closed-record policies traditionally followed by adoption

433. *C.M.* v. *C.C.*, 377 A. 2d 821 (1977) (known donor has parental rights); *Jhordan C.* v. *Mary K.*, 179 Cal. App. 3d 386 (1986) (donor is child's father).

434. *Snede* v. *Wayne State Univ.* (15 July 1980), E.D. Mich. 80-725-83. See Patricia A. Kern and Kathleen M. Ridolfi, "The Fourteenth Amendment's Protection of a Woman's Right to Be a Single Parent through Artificial Insemination by Donor" (1982) 7 Women's Rights L. Rep. 251 at 254 n. 22 for a description of the plaintiff's brief in this case.

435. OLRC, *supra*, note 2 at 154.

agencies.[436] Recent studies have recognized that the disclosure of information to an adult adoptee is desirable as long as such disclosure does not conflict with the birth parents' right to withhold identifying information if they so desire. It was recommended that the right of a birth parent or the donor of genetic material to remain anonymous should prevail over the child's right to be informed.[437]

In the United States, constitutional challenges to closed-adoption-record laws on the grounds that adoptees have a fundamental right to know their biological origins have not succeeded. The courts have generally held that closed-record laws achieve a desirable balance between the birth parents' privacy rights, the state's interest in protecting the integrity of the adoption process, and the adoptees' need for information.[438]

Section 7 of the *Charter* requires that a distinction be drawn between information that discloses the identity of the biological parents and that which does not. The release of non-identifying genetic and medical information is often necessary to the physical well-being of the child conceived through medically assisted procreation. The majority in *Morgentaler*[439] recognized that security of the person included a right of access to medical treatment for a condition that represents a danger to life or health. Refusal to disclose information necessary to the preservation of life and health would similarly interfere with the security of the person conceived by means of medically assisted procreation. Legislation that provided for the automatic release of non-identifying information would protect the interests of the person so conceived without compromising the privacy rights of donors.

On the other hand, the disclosure of identifying information raises a clear conflict between the interests of the child in knowing the identity of his or her biological parents and the interests of donors in remaining anonymous. Many donors participate in medically assisted procreation programs on condition that they remain anonymous. Provisions for

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436. Knoppers, *supra*, note 260; Ontario, Ministry of Community and Social Services, *Ontario's New Adoption Disclosure Policy* (Toronto: Queen's Printer for Ontario, 1986); *Background Paper on the Establishment of an Adult Adoption Disclosure Registry in British Columbia* (Victoria, B.C.: Ministry of Social Services and Housing, 1986); Community Task Force on Maternal and Child Health, *Adoption: Acquisition and Disclosure of Records* (Winnipeg, Man.: The Task Force, 1981); Manitoba Law Reform Commission, *Working Paper on Confidentiality of Adoption Records* (Winnipeg, Man.: The Commission, 1979); Barreau du Québec, *Mémoire du Comité du Barreau du Québec sur la confidentialité des dossiers d'adoption et la recherche des antécédents* (Montreal: The Bar, 1986); Clare Marcus, *Adopted? A Canadian Guide for Adopted Adults in Search of Their Origins* (Vancouver, B.C.: International Self-Counsel Press, 1979).

437. See Knoppers, *supra*, note 260.

438. See *Alma Society Incorporated* v. *Mellon*, 601 F. 2d 1225 (1979); *Re Roger B.*, 84 Ill. 2d 325 (1981); Debra D. Poulin, "The Open Adoption Records Movement: Constitutional Cases and Legislative Compromise" (1987-88) 26 J. Fam. L. 395; Heidi A. Schneider, "Adoption Contracts and the Adult Adoptee's Right to Identity" (1988) 6 Law & Inequality 185; Carolyn Burke, "The Adult Adoptee's Constitutional Right to Know His Origins" (1975) 48 S. Cal. L. Rev. 1196; Marilee C. Unruh, "Adoptee's Equal Protection Rights" (1981) 28 U.C.L.A. L. Rev. 1314.

439. *Supra*, note 336.

the disclosure of identifying information would therefore jeopardize the operation of programs and interfere with the privacy interests of donors. In the face of these equally compelling competing claims, section 7 would not be violated by legislation that prohibited the disclosure of identifying information without the consent of the donor.[440]

C. Section 15 Equality Rights

Section 15 provides, in part, as follows:

> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

A framework for the analysis of equality claims was set out recently by the Supreme Court in *Andrews* v. *Law Society of British Columbia*.[441] Justice McIntyre, writing for a majority of the Court on the interpretation of subsection 15(1), expressed the goal of section 15 as follows:

> [T]he admittedly unattainable ideal should be that a law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another.[442]

As is the case for section 7, to establish a violation of section 15 one must follow a two-step process: first, one must establish a violation of one of the four basic equality rights guaranteed by section 15,[443] and second, one must establish that the impact of the law is discriminatory.[444]

The Court has defined the "minimal content of the right to equality before the law" as follows:

> The guarantee of equality before the law is designed to advance the value that all persons be subject to the equal demands and burdens of the law and not suffer any greater disability in the substance and application of the law than others.[445]

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440. Most recent reports on both adoption and medically assisted procreation have recommended that non-identifying information be made readily available and that identifying information be released only with the consent of the biological parent. See Knoppers and Sloss, *supra*, note 269 at 693-96; Knoppers, *supra*, note 260 at 832-33; Ontario, Ministry of Community and Social Services, *supra*, note 436.

441. [1989] 1 S.C.R. 143.

442. *Ibid.* at 165.

443. *Turpin*, *supra*, note 417. A litigant must show that he or she is not receiving equal treatment before or under the law or that the law has a differential impact on him or her in the protection or benefit accorded by the law.

444. *Andrews*, *supra*, note 441 at 182.

445. *Turpin*, *supra*, note 417 at 1329.

With respect to the concept of discrimination, in the *Andrews* decision Justice McIntyre referred to and adopted the following definition of discrimination from the *Action Travail des femmes* case:

> Discrimination ... means practices or attitudes that have, whether by design or impact, the effect of limiting an individual's or a group's right to the opportunities generally available because of attributed rather than actual characteristics. ...
>
> It is not a question of whether this discrimination is motivated by an intentional desire to obstruct someone's potential, or whether it is the accidental by-product of innocently motivated practices or systems. If the barrier is affecting certain groups in a disproportionately negative way, it is a signal that the practices that lead to this adverse impact may be discriminatory.[446]

Justice McIntyre then proposed the following definition of discrimination:

> [D]iscrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.[447]

Not every legislative distinction will constitute discrimination. The Supreme Court has made it clear that only laws that have an unequal impact on groups of persons having in common any of the characteristics that constitute an enumerated or analogous ground can constitute discrimination for the purpose of section 15. A law that has an unequal impact on persons who cannot be associated with a group contemplated in section 15 cannot be considered discriminatory. The Court emphasized that the test for the eligibility of a group for section 15 protection lay in a situation of social, political or legal disadvantage related to a ground analogous to those enumerated in section 15. In *Andrews*, the Court stressed that non-citizens lack political power, have suffered a history of discrimination, and therefore constitute a good example of a discrete and insular minority deserving of section 15 protection.

On the other hand, in *Reference Re* Workers' Compensation Act, 1983 *(Nfld)*,[448] the Court summarily dismissed a challenge to a workers' compensation statute that denied access to the courts to victims of workplace accidents and their dependents. The court was unanimously of the view that the statute did not create any discrimination within the meaning of section 15, since

> [t]he situation of the workers and dependents here is in no way analogous to those listed in s. 15(1), as a majority in *Andrews* stated was required to permit recourse to s. 15(1).[449]

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446. *Andrews*, *supra*, note 441 at 174, quoting from *Canadian National Railway Co.* v. *Canada (Canadian Human Rights Commission)*, [1987] 1 S.C.R. 1114 at 1138-39.

447. *Andrews, supra,* note 441 at 174-75.

448. [1989] 1 S.C.R. 922.

449. *Ibid.* at 924.

Similarly, in *Turpin*[450] the Court rejected a challenge by accused persons outside the province of Alberta to a provision of the *Criminal Code* that provided accused persons in Alberta, but not elsewhere, the right to choose to have a trial by judge alone. Speaking for the Court, Justice Wilson rejected the claim on the grounds that accused persons outside Alberta did not constitute an analogous group for the purposes of section 15:

> [I]t would be stretching the imagination to characterize persons accused of one of the crimes listed in s. 427 of the *Criminal Code* in all the provinces except Alberta as members of a "discrete and insular minority." . . . Differentiating for mode of trial purposes between those accused of s. 427 offences in Alberta and those accused of the same offences elsewhere in Canada would not, in my view, advance the purposes of s. 15 in remedying or preventing discrimination against groups suffering social, political and legal disadvantage in our society. A search for indicia of discrimination such as stereotyping, historical disadvantage or vulnerability to political and social prejudice would be fruitless in this case because what we are comparing is the position of those accused of the offences listed in s. 427 in the rest of Canada to the position of those accused of the offences listed in s. 427 in Alberta. . . . Persons resident outside Alberta and charged with s. 427 offences outside Alberta do not constitute a disadvantaged group in Canadian society within the contemplation of s. 15.[451]

It follows that any attempt to regulate access to reproductive technologies by the use of rules that would have a disparate impact on an enumerated or analogous group would violate section 15. Conversely, rules that have a disparate impact on groups not analogous to the enumerated groups would not be discriminatory for the purposes of section 15. For example, an argument by an infertile couple that a rule limiting access to reproductive technologies discriminates against the infertile as a class is not likely to succeed. The infertile do not constitute a discrete and insular minority that have suffered a history of disadvantage or a lack of political power.[452]

On the other hand, rules that discriminate or have a disparate impact on groups with respect to an enumerated ground such as sex, or an analogous ground such as marital status, parental status,[453] family status or sexual orientation, will be vulnerable to a section 15 challenge.

One of the clearest examples of a non-enumerated, but nevertheless protected, ground of discrimination is marital status. It is a ground of discrimination expressly prohibited

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450. *Supra*, note 417.

451. *Ibid.* at 1333.

452. It may be that rules will impose an unequal burden on a subset of the group of infertile people defined by their sex, class, marital status or sexual orientation. In that case, the possibility of making out a case of discrimination on a prescribed ground arises. See Martha A. Field, *Surrogate Motherhood*, expanded ed. (Cambridge, Mass.: Harvard University Press, 1990) at 47-49 for a discussion of these issues.

453. For an example of discrimination on the basis of parental status, see *Symes* v. *Canada*, [1989] 3 F.C. 59 at 81-82 (T.D.). It should be noted that the trial decision was reversed on other grounds (19 June 1991) A-290-89 (C.A.).

by human rights legislation in every Canadian jurisdiction.[454] In addition, family status is a prohibited ground of discrimination in federal legislation, and in Manitoba,[455] Ontario[456] and the Northwest Territories.[457] Discrimination against an individual based on his or her status as a single, married, divorced or widowed person is prohibited. Case law interpreting these legislative human rights guarantees has increasingly affirmed the principle that rules cannot be based on distinctions drawn upon stereotypical characteristics associated with the family status of an individual without a consideration of his or her actual situation or merits as they relate to the benefit or service at issue.[458]

It is generally recognized that marital and family status are grounds of discrimination that ought to be recognized under section 15 of the *Charter*. For example, the Parliamentary Committee on Equality Rights concluded as follows:

> We believe that section 15 of the *Charter* should be read against the historical background of the treatment in law of married women and the recognition nationally and internationally that marital and, in many cases, family status deserve protection by the state. Accordingly, while section 15 does not specifically prohibit discrimination on the basis of marital or family status, we believe that the ground can be properly read into the open-ended language of the section. In other words, marital or family status is implicitly covered by section 15.[459]

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454. *Canadian Human Rights Act*, S.C. 1976-77, c. 33; *Fair Practices Act*, R.S.N.W.T. 1988, c. F-2; *Human Rights Act*, S.Y.T. 1987, c. 3, s. 6 (k); *Human Rights Act*, S.B.C. 1984, c. 22; *Individual Rights Protection Act*, R.S.A. 1980, c. I-2; *The Saskatchewan Human Rights Code*, S.S. 1979, c. S-24.1, s. 12(1); *The Human Rights Code*, S.M. 1987-88, c. 45, s. 9(2)(i); *Human Rights Code, 1981*, S.O. 1981, c. 53, s. 1; Quebec Charter, *supra*, note 255, s. 10 (''civil status''); *Human Rights Act*, R.S.N.B. 1973, c. H-11; *Human Rights Act*, R.S.N.S. 1989, c. 214, s. 12(2); *Human Rights Act*, R.S.P.E.I. 1988, c. H-12; *The Human Rights Code*, S.N. 1988, c. 62. See generally A. Anne McLellan, ''Marital Status and Equality Rights'' in Anne F. Bayefsky and Mary Eberts, eds, *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985) at 411.

455. *The Human Rights Code*, *supra*, note 454, s. 9(2)(i).

456. Ontario defines family status to mean ''the status of being in a parent and child relationship.'' *Human Rights Code, 1981*, *supra*, note 454, s. 9(1)(d).

457. *Fair Practices Act*, *supra*, note 454.

458. *Brossard (ville)* v. *Québec (Commission des droits de la personne)*, [1988] 2 S.C.R. 279 at 298 (municipality's blanket anti-nepotism policy discriminated on the basis of civil status); *Cashin* v. *Canadian Broadcasting Corporation*, [1988] 3 F.C. 494 (C.A.); *Saskatchewan Human Rights Commission* v. *Saskatchewan (Department of Social Services)* (1988), 52 D.L.R. (4th) 253 (Sask. C.A.) (lower welfare benefits to single persons constitutes discrimination on the basis of marital status under the provincial human rights code); *Schaap* v. *Canadian Armed Forces*, [1989] 3 F.C. 172 at 184 (C.A.), Hugessen J.: employer's policy of granting family accommodation only to married couples

> perpetuates a stereotype, namely, that a relationship between a man and a woman has a lesser social value if it does not have the status of marriage. . . . It is a commonplace that the existence of the marriage bond is no guarantee of the permanency and stability of a relationship, just as its absence is no sure indicator of a mere passing fancy.

See, however, *Canada (Attorney General)* v. *Mossop*, [1990] 1 F.C. 18 (C.A.), rev'g *Mossop* v. *Canada (Secretary of State)* (1989), 10 C.H.R.R. D/6064.

459. Canada, House of Commons, Sub-committee on Equality Rights, *Equality for All: Report of the Parliamentary Committee on Equality Rights* (Ottawa: Queen's Printer, 1985) at 34 (Chair: J. Patrick Boyer).

In *Re MacVicar and Superintendent of Family and Child Services*,[460] the Court concluded that discrimination on the basis of marital status was prohibited by the *Charter*:

> Marital status is a direct result of a personal decision whether or not to marry with the blessing of the State and thereby obtain certain rights and incur certain obligations. . . . Marital status, in itself, bears no relationship to ability to nurture a child and consider its best interest.[461]

Similarly, there is a growing recognition of the need to provide legal recognition of the rights of sexual minorities.[462] The Parliamentary Committee on Equality Rights concluded that "'sexual orientation' should be read into the general open-ended language of section 15 of the *Charter* as a constitutionally prohibited ground of discrimination."[463] Sexual orientation is a ground of discrimination not enumerated in section 15, but is analogous to the enumerated grounds in that gay men and lesbian women constitute discrete and insular minorities that have suffered a history of discrimination.[464] Sexual orientation is now a prohibited ground of discrimination in Quebec, Ontario, Manitoba and the Yukon.[465]

In sum, there is little doubt that any legislative limitations placed on access to reproductive technologies will have to be tailored to avoid discrimination on the basis of family status, marital status and sexual orientation. On the other hand, legislation requiring applicants to be assessed on the basis of their merits and capacities as potential parents would not violate section 15. Such an approach would also be in line with current Canadian adoption law and the recommendations contained in several provincial reports concerning reproductive technologies. For example, Ontario adoption law has recently been changed

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460. (1986) 34 D.L.R. (4th) 488 (B.C.S.C.).

461. *Ibid.* at 497. See also *M.(N.)* v. *British Columbia (Superintendent of Family and Child Services)* (1986), 10 B.C.L.R. (2d) 234 (S.C.).

462. See James E. Jefferson, "Gay Rights and the *Charter*" (1985) 42 U.T. Fac. L. Rev. 70; Margaret Leopold and Wendy King, "Compulsory Heterosexuality, Lesbians and the Law: The Case for Constitutional Protection" (1985) 1 C.J.W.L. 163; Arnold Bruner, "Sexual Orientation and Equality Rights" in Bayefsky and Eberts, eds, *supra*, note 454 at 457; Philip Girard, "Sexual Orientation as a Human Rights Issue in Canada 1969-1985" (1986) 10 Dalhousie L.J. 267. But see *Andrews*, *supra*, note 441. For a summary of the law in the United States, see Note, "Developments in the Law: Sexual Orientation and the Law" (1989) 102 Harv. L. Rev. 1508. See also Philip Girard, "The Protection of the Rights of Homosexuals under the International Law of Human Rights: European Perspectives" (1986) 3 Can. Hum. Rts Y.B. 3.

463. *Equality for All*, *supra*, note 459 at 29.

464. See Leopold and King, *supra*, note 462; Jefferson, *supra*, note 462; *Watkins* v. *United States Army*, 837 F. 2d 1428 (1988), aff'd 875 F. 2d 699 (1989).

465. Quebec Charter, *supra*, note 255, s. 10; *Human Rights Code, 1981* (Ontario), *supra*, note 454, as am. S.O. 1986, c. 64, s. 18; *The Human Rights Code* (Man.), *supra*, note 454, s. 9(2)(h); *Human Rights Act* (Yukon), *supra*, note 454, s. 6.

to allow for equal consideration of single applicants,[466] as is the case in all other Canadian jurisdictions.[467] Similarly, three recent provincial reports on reproductive technology recognized that limiting access to married couples would violate human rights laws. The Ontario Law Reform Commission concluded that restricting access to reproductive technologies to couples

> would appear to contravene human rights legislation applicable in this Province. Moreover, any *a priori* exclusions based simply on membership in a particular group (such as married persons) would automatically eliminate from consideration single persons or unmarried couples who, by any standard, would make suitable parents.[468]

The Ontario Law Reform Commission accordingly recommended that eligibility to participate in a medically assisted procreation program "should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions."[469] Similarly, the British Columbia Royal Commission proposed that the guiding standard should be an applicant's "ability to nurture":

> [A]n attempt to judge the recipient in terms of her conformity to prevailing mores about marriage and lifestyle should be made in the context of their current state of flux and, more importantly, should concentrate on the conduct of the individual which can be shown to relate directly to her ability to nurture. As suggested above, the central concern in evaluating the prospective AID recipient should focus directly (and singularly) on her ability to be a successful parent. It is the potential child's interest which must be paramount in this situation.[470]

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466. *Child and Family Services Act, 1984*, *supra*, note 309, s. 140. Previously the law would only allow for the consideration of unmarried applicants in "special circumstances." The change was explained in the background paper to the legislation as follows:

> Aside from a recognition of the changing concepts of marriage and the family, requirements imposed by Ontario's Human Rights Code have contributed to the elimination of the "special circumstances" qualification for unmarried adoptive applicants. Hence, single applicants will be eligible for consideration as adoptive parents. It is, however, anticipated that in most cases adoption practice would continue to reflect a strong preference for a two-parent family based on considerations of the child's best interests.

Ontario, Ministry of Community and Social Services, *The Child and Family Services Act: Draft Legislation and Background Paper* (Toronto: The Ministry, 1983) at 136.

467. *Child Welfare Act* (Alta), *supra*, note 309, s. 56, as am. S.A. 1988, c. 15, s. 35; *Adoption Act* (B.C.), *supra*, note 309, s. 3; *The Child and Family Services Act* (Man.), *supra*, note 309, ss 66(1), 71(1); *Family Services Act* (N.B.), *supra*, note 283, s. 66; *The Adoption of Children Act, 1972* (Nfld), *supra*, note 309, s. 4(1); *Children and Family Services Act* (N.S.), *supra*, note 309, s. 72(1) and (2); *Adoption Act* (P.E.I.), *supra*, note 309, s. 3(1); *C.C.Q.*, arts 598-599; *The Adoption Act* (Sask.), *supra*, note 309, s. 17(2)(b); *Children's Act* (Yukon), *supra*, note 197, s. 79(1).

468. OLRC, *supra*, note 2 at 158.

469. *Ibid.* at 275.

470. British Columbia Royal Commission on Family and Children's Law, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination* (Vancouver: The Royal Commission, 1975) at 10-11. See also Law Reform Commission of Saskatchewan, *Tentative Proposals for a Human Artificial Insemination Act* (Saskatoon, Sask.: The Commission, 1981) at 1-3:

> [I]t would appear that if a physician or medical institution which generally offers artificial insemination services to the public refuses to inseminate an unmarried woman solely because of her marital status, *The Saskatchewan Human Rights Code* would be violated.

If a limit on access is considered necessary, such an approach, similar to the criteria applied in Canadian adoption law, would be needed to satisfy the requirements of section 15 of the *Charter*. In addition, in light of the definition of discrimination set forth by the Supreme Court,[471] care will have to be taken to ensure that the criteria chosen to regulate access to reproductive technologies do not unjustly burden a group of prospective parents defined by reference to one of the grounds enumerated in section 15 (or a ground analogous to those enumerated in section 15).

For example, let us consider infertility as a potential criterion for access to a reproductive technology. In the case of IVF, legislation making demonstrated infertility a precondition for access would be constitutionally unimpeachable. IVF is a procedure that will mainly be sought by women who are infertile; fertile women can bear children without the assistance of IVF. However, making infertility a precondition for access to surrogate motherhood and AI would give rise to section 15 objections. Such a requirement would impose a disproportionate burden on fertile men and women who wish to exercise their right to procreate non-coitally. These people are defined by their lack of a heterosexual partner, which is to say, by their marital status or their sexual orientation. Legislation imposing infertility as a requirement for access to AI and surrogacy arrangements would effectively deny these men and women the right to procreate. This disproportionate burden suffered by individuals as a result of their marital status or sexual orientation would constitute discrimination for the purposes of section 15.

In addition, care will have to be taken to ensure that criteria neutral on their face in terms of their impact on groups protected by section 15 or analogous groups, such as "ability to parent," are not in practice applied in such a way as to impose an unequal burden on unmarried, single, gay or lesbian applicants for access to reproductive technologies.

D. Section 1

A law that infringed a right or freedom guaranteed in the *Charter* would not be unconstitutional provided that it conformed to the criteria set out in section 1 of the *Charter*. Section 1 provides as follows:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

471. See *Andrews*, *supra*, note 441; *Turpin*, *supra*, note 417.

For a limitation on rights to be upheld, it must be prescribed by law. This requirement was explained by Justice Le Dain in the following terms:

> The requirement that the limit be prescribed by law is chiefly concerned with the distinction between a limit imposed by law and one that is arbitrary. The limit will be prescribed by law within the meaning of s.1 if it is expressly provided for by statute or regulation, or results by necessary implication from the terms of a statute or regulation or from its operating requirements. The limit may also result from the application of a common law rule.[472]

This means that any restrictions on access that would constitute an infringement of the *Charter* must be set out in legislation. Limitations that resulted from the application of policy guidelines or other directives without legal force would not be considered as "prescribed by law" for the purposes of section 1.

With respect to the other requirements of section 1, the basic framework was established by the Supreme Court in *R.* v. *Oakes*.[473] In *Oakes*, the Court held that the legislative objective must be sufficiently important to justify the infringement of rights, and that the means chosen must be reasonable and justified in terms of the objectives sought.

There are certain limitations on the kinds of arguments that courts will entertain under section 1 with respect to such objectives. First, one cannot rely upon a legislative objective that is *ultra vires* Parliament or the legislature or is otherwise itself a violation of the *Charter*.[474] Second, the objective pleaded in justification must be that which actually underlay the legislation, not one that was invented after the fact for the purposes of argument before the courts.[475]

These limitations aside, courts have tended to accept legislative objectives as sufficiently important to justify limitations on rights: most cases turn on the question of whether the limitations on rights were reasonable under the circumstances. In this respect, it is difficult to predict how a court would apply section 1 to any law restricting access to medically assisted procreation. It is now a commonplace to observe that the Supreme Court is divided on the question of how to apply section 1 of the *Charter*, and it is impossible to conclude that section 1 is being applied in a consistent manner.[476] In some cases courts have ruled

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472. *R.* v. *Therens*, [1985] 1 S.C.R. 613 at 645.

473. [1986] 1 S.C.R. 103.

474. *R.* v. *Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at 362 (per Dickson J., as he then was).

475. *Ibid.* at 362.

476. Marc Gold, "Of Rights and Roles: The Supreme Court and the *Charter*" (1989) 23 U.B.C. L. Rev. 507; Robin M. Elliot, "The Supreme Court of Canada and Section 1 - The Erosion of the Common Front" (1987) 12 Queens L.J. 277; Lorraine Eisenstat Weinrib, "The Supreme Court of Canada and Section One of the *Charter*" (1988) 10 Supreme Court L.R. 469.

that government must give compelling reasons for its laws, while in others courts have shown a considerable degree of deference to the legislature.[477] Indeed, recent cases leave unresolved the central question concerning the standard of review to apply in equality rights cases: whether different standards are to apply depending on the nature of the case and, if so, what those standards are.[478] This considerably complicates the task of predicting how a court might apply section 1 to the issues considered in this study.

477. See *R.* v. *Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713; *Jones*, *supra*, note 336.

478. The division on the Court is clear in *Andrews*, *supra*, note 441. See Marc Gold, "Comment: *Andrews* v. *Law Society of British Columbia*" (1989) 34 McGill L.J. 1063.

CHAPTER THREE

The Role of the State

There is currently no legislation in Canada that deals specifically with medically assisted procreation,[479] but the technologies are subject to other types of control.[480] We must therefore determine the adequacy of these controls before we can decide if legislation in this area is appropriate. Generally speaking, we cannot recommend greater state intervention in medically assisted procreation without considering the role of the state and of the federal government in this field.

I. The Scope of Existing Controls

Among the control mechanisms now in place are individual control based on the parties' individual responsibility and freedom of choice; professional and socio-professional control focusing on the quality of medical practice and the ethical aspects of applying scientific discoveries; community control exercised by permanent ethics committees (provincial and/or national) and the courts; and legislative and regulatory control.

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479. With the exception of provisions in some provinces respecting parentage. See *supra*, chap. 2.

480. See Guy Rocher, "Pour une sociologie des ordres juridiques" (1988) C. de D. 91 at 117-18:

> [TRANSLATION]
> The medical profession has behind it a long tradition of self-regulation. In this respect it is a very old legal order outside the state itself. In the absence of legislation or precedents, the College of Physicians has established its own rules and standards and a code of ethics that serve as law for members of the association. Through ethics committees, disciplinary committees or other means, physicians in hospitals set standards to regulate their conduct and their relations with their patients (and other medical personnel). The medical profession is a typical case of agents or instruments being recognized as having the authority to develop, interpret and enforce rules that have all the characteristics of law but do not originate with the state. . . . Of course, none of this stands in the way of state regulation. What must be considered, then, is the exact source of state regulation: what non-governmental legal order has the credibility, power and influence needed to ensure acceptance of its standards? What compromise will state regulation (by a legislature or a court of law) strike between the standards of several concurrent non-governmental legal orders?

A. Individual Control: The Private Ordering Approach and Individual Responsibility[481]

Absolute priority is given here to individual freedom and the right to privacy. The individuals concerned make their own arrangements and no value-judgment is made regarding their choice. The assessment of the risks and benefits that are part of medically assisted procreation and the decision whether or not to use a technology are left to the free will of the people involved. The role played by lawmakers may be active or passive in that a legislature may specifically entrench freedom of choice in a statute or regulation, or may give tacit approval to such freedom.[482] Without intervening at the outset, it can nevertheless regulate some of the outcomes of private decisions. For example, while it does not become involved in a couple's decision to marry and raise a family, it establishes the property and other rights and obligations of the spouses and the children, as well as the parentage of the children.

This approach has the advantage of focusing on individual responsibility and initiative. It allows every member of a pluralistic society to conduct himself or herself according to his or her own beliefs, without undue interference by the state and without the state imposing a specific set of morals on everyone.[483] It ensures that there is no conflict with the freedom and privacy rights guaranteed by the Constitution and at issue in procreation. The decision to conceive is therefore a purely private one, a moral choice to be left to individuals.[484]

The state does not intervene in natural reproduction.[485] As the Ontario Law Reform Commission has pointed out, the "best interest of the child" is never put forward to justify an intrusion into the private lives of couples or individuals. This criterion was used in the past for eugenic and financial reasons in legislation providing for the forced sterilization of mentally retarded persons, criminals and members of ethnic minorities, but this sort of motivation is no longer considered acceptable;[486] the human rights charters and court rulings guarantee this.

Furthermore, treatment for sterility (hormone therapy, surgery, and so on) is one of the medical services available to the public, and the marital status and psychological profile

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481. See Frances E. Olsen, "The Family and the Market: A Study of Ideology and Legal Reform" (1983) 96 Harv. L. Rev. 1497 at 1504.

482. OLRC, *supra*, note 2 at 106ff.

483. John A. Robertson, "Embryo Research" (1986) 24 U.W.O. L. Rev. 15 at 27.

484. OLRC, *supra*, note 2 at 106ff.; Robertson (1986), *supra*, note 381 at 1040; The American Fertility Society, The Ethics Committee, *supra*, note 187 at 5S.

485. It may intervene to sanction illicit sexual relations. In this case, however, the purpose is to protect persons who are exposed to exploitation, not to intervene in a joint decision to procreate: OLRC, *supra*, note 2 at 106ff.

486. LRC, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, Working Paper 24 (Ottawa: Supply and Services Canada, 1979); Symposium of the Association québécoise pour l'étude comparative du droit, "L'affaire *Eve* et la stérilisation des déficients mentaux" (1987) 18 R.G.D. 641.

of those undergoing such treatment are not scrutinized.[487] If this is the case, why would we wish to treat "artificial" reproduction differently than natural reproduction? Is artificial procreation, too, not a part of the "private ordering approach" insofar as the actual decision to conceive is concerned?[488]

For those opposed to state intervention in medically assisted procreation, society is in the process of coming to terms with all these discoveries and will ultimately consider their use a matter of course, as has been the case with so many other discoveries in the past. However, most defenders of this approach recognize the need to attach certain legal consequences to individual choices and to impose controls over the way at least some of the technologies are applied. These controls will be examined later, but suffice it to say for the time being that, in general, they are designed to ensure the quality of the services provided and, by extension, to protect the "recipients." In any event, defenders of this position do not question the legitimacy of using the various technologies associated with medically assisted procreation.

Individual freedom can also be advocated at this stage simply because any intervention is considered premature, as discussion of the issues is not yet sufficiently advanced to permit standards to be issued. What is therefore needed is community-wide reflection.[489]

A full private ordering approach does not, however, have widespread support. It fails to answer any of the fundamental questions raised by the application to humans of scientific discoveries in the area of procreation, and it does not provide conscientious researchers with the guidelines they are seeking. It also creates difficulties in terms of the administration of justice. For example, the legal status of children born of medically assisted procreation has yet to be resolved, and control of gametes and embryos is foundering in a legal void.

The role of individual control in medically assisted procreation can be increased with proper public awareness and education. The task is to present the issues associated with new technologies to the public as objectively as possible. First to be addressed are the issues that affect individuals: the advantages and disadvantages for those using the technologies, the success and failure rate of each technology in the context in which it is used; and the physical and psychological risks for all of the people concerned. Next are the issues that affect future generations and society as a whole: the longer-term issues for the embryo, the fetus, the unborn child and the future of the human race; the fate of surplus embryos; the possible benefits to researchers — in short, all the major issues

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487. OLRC, *supra*, note 2 at 110.

488. *Ibid.* at 118. Thomas A. Eaton, "Comparative Responses to Surrogate Motherhood" (1986) 65 Neb. L. Rev. 686 at 707.

489. Rubellin-Devichi, *supra*, note 314 at 457-59.

currently being debated in various forums. However, it is difficult to guarantee that public education will be objective because it will always be based on information from many different sources. It could therefore be influenced by the fragmentation of the sources of information and might even be distorted by the unbridled confidence of some researchers and the sensationalism that sometimes characterizes the media.

This approach may also be accompanied by a promotion of values designed to instil a sense of responsibility in all the individuals concerned, and remind them that respect for human dignity must always take precedence over immediate individual interests. The positions taken by moral and religious authorities reflect this trend.[490]

Similar views can be seen in the positions adopted by various ethics bodies, which we will discuss later. Again, these positions must be conveyed to the general public, as the National Advisory Ethics Committee for the Life and Health Sciences in France is endeavouring to do.[491] The recommendations of the American Fertility Society also stress the dissemination of information and moral counsel and the use of persuasion to enable people to make informed choices and gradually to alter public attitudes.[492]

These and other similar measures are vital to a better understanding by the general public of the real issues at stake in medically assisted procreation. But the basic information must from the start be non-denominational and non-political. And it should not be associated with specific groups, such as scientists, health professionals and women, although these groups do have an important role to play. No matter how active they might be in public education, these groups do not always display the objectivity needed to provide neutral information.[493]

One might ask what type of audience is reached by ethics bodies and moral and religious authorities? For Jacqueline Rubellin-Devichi, the opinions they issue have a considerable influence on public opinion.[494] This is probably the case in Europe, but does it also hold true in Canada?

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490. See, in particular, Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* (Vatican City: Vatican Polyglot Press, 1987); Gérard Mémeteau, "Le Comité National Consultatif d'Éthique et l'enfant conçu" in *La vie prénatale, biologie, morale et droit: Actes du VI^e Colloque national des Juristes Catholiques, Paris, 15-17 novembre 1985* (Paris: TÉQUI, 1986) at 67; Edouard Bone and Jean-François Malherbe, *Engendrés par la science: Enjeux éthiques des manipulations de la procréation* (Paris: Cerf, 1985) at 33, referring to the suggestion in this connection of some Nobel Prize winners regarding "reproduction permits" and "quality tests" of the newborn child.

491. Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *Journées annuelles d'éthique* (Paris: La Documentation française, 1986) at 31.

492. The American Fertility Society, The Ethics Committee, *supra*, note 187 at 21Sff. and 73Sff.

493. For example, some view reproductive technologies as nothing more than exploitation of women's bodies for scientific research and "production" and as a result fail to see their contribution to procreation. This type of attitude was evident during the international forum, *Sortir la maternité du laboratoire* (Quebec: Conseil du statut de la femme, 1988). On the other hand, the attitudes reflected in studies such as the Conseil du statut de la femme, *Nouvelles technologies de la reproduction: pratiques cliniques et expérimentales au Québec* (Quebec: The Council, 1986) and the study by the Alberta Advisory Council on Women's Issues, *Discussion Paper on New Reproductive Technologies: Medical, Legal and Ethical Implications* (Edmonton: The Council, 1988), bear witness to the important contribution of these groups.

494. *Supra*, note 314 at 457.

The position taken by the Catholic Church, which opposes medically assisted procreation outright, raises some reservations.[495] For the United Church, artificial insemination with donor may be a legitimate choice in terms of ethics and morality.[496] Surrogate motherhood itself could be admissible in very special circumstances.[497]

Is education alone enough, given the issues raised by medically assisted procreation? Apparently not: education will raise awareness but has no compelling influence. It therefore offers no protection against the dangers of abuse or against commercialization of the technologies. As Jean-Louis Baudouin and Catherine Labrusse-Riou point out, it is unrealistic to rely on self-discipline.[498] Public education is an important, even essential, step because we are looking for the solution or solutions to what is first and foremost a problem for all of society and not just an individual problem. Public education can discourage the abuse or inappropriate use of the technologies made possible by science, but it is unlikely to have any impact on unscrupulous people.

B. Professional Control

The quality of a medical treatment may be controlled as to both its indication and its performance. Control may go beyond this practical stage and question the moral value of applying scientific discoveries; this is the role of ethics. In this regard, standards may be issued by professional associations or recommended by multidisciplinary committees.

1. The Medical Profession

Procreation assistance technologies are a type of therapeutic treatment and are naturally a part of the medical profession. This is certainly true of the more complex technologies that require special resources and a special environment. Artificial insemination, on the other hand, can easily be performed without special training. However, it is not without risk.

Physicians are required to comply with the standards of good medical practice as defined by their professional associations within limits set by the courts. These standards are designed to protect the public from unqualified individuals[499] — in other words, malpractice or unlawful practice — and to set a benchmark for professional practice that

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495. Congregation for the Doctrine of the Faith, *supra*, note 490 at 5ff.: the Congregation bases its opposition on the separation of sexual relations and procreation, which in its view fails to respect the dignity of the person. It fears the "technologization" of procreation. The Ethics Committee of the American Fertility Society has published a second discussion paper in response to the Instruction from Rome: "Ethical Considerations of the New Reproductive Technologies" (1988) 49:2 (Supp. 1) Fertil. Steril.

496. United Church of Canada, Division of Mission in Canada, "A Brief to the Royal Commission on New Reproductive Technologies," 1991, at 9-10 [unpublished].

497. *Ibid.* at 12.

498. *Supra*, note 210 at 208.

499. *Ibid.*

may be considered by the courts in the event of a dispute.[500] Assuming that professional associations adopt positions on the basic legitimacy of assisted procreation, as some have already done,[501] and set ethical guidelines for the use of new technologies by their members, effective sanctions must be devised for those who violate these guidelines.[502] Standards, where they do exist, have no legal force unless they are included in regulations, as is the case, for example, with the Quebec codes of professional ethics.

In France, the Conseil d'État recommends specific sanctions for professional misconduct and urges professional associations to endeavour to prevent the misuse of new technologies. It even suggests that criminal sanctions be imposed for violating basic rules and procedures and for ignoring the advice of an ethics committee.[503] Even then there is the problem of enforcement, especially when such fundamental choices are involved. Further, there is something of a tradition of secrecy and moral independence surrounding professional associations, and this could raise doubts about their ability to ensure real control that is sufficiently credible to the public. And if control of the application of discoveries were left to professional associations, standards would perhaps vary from one association to another, from one province to another and from one country to another, and it would be impossible to set the standard rules that most of those involved would like to see adopted.

Finally, as the members of the Quebec task force noted, [TRANSLATION] "regulation of human reproduction technologies is a matter of social policy that must not be identified with the development of standards for the professional quality of the services." The task must therefore "not be left to the medical profession or to the other professions that are directly involved."[504]

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500. For example, standards issued by The American Fertility Society influenced the court in *York* v. *Jones Institute*, *supra*, note 204 (transfer of a frozen embryo from one clinic to another). See also P. Widmer, "Les perspectives législatives, en particulier vues du Conseil de l'Europe" in *Artificial Procreation, Genetics and the Law: Lausanne Colloquium of November 29-30, 1985* (Zurich: Schulthess Polygraphischer Verlag, 1986) 211 at 213. For a general discussion of the role of the courts, see "The Courts," *infra* at 110.

501. On all or only some technologies. For example, The American Fertility Society, The Ethics Committee, *supra*, note 187 at 62Sff., favours considerable reproductive freedom but is opposed to surrogate motherhood for convenience and has reservations about the actual process. The Swiss Academy of Medical Sciences in *Directives médico-éthiques pour la procréation médicalement assistée* (Petersplatz: The Academy, 1990) recognizes the validity of in vitro fertilization for medical reasons, provided it is performed in the case of married couples or unmarried couples living a conjugal life (directive 3.1 at 2) and rejects surrogate motherhood (directive 12.6 at 5). The Conseil de l'Ordre des médecins in France accepts procreation assistance within the couple, has reservations about the intervention of unknown donors, and rejects surrogate motherhood and embryo donation: in Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *supra*, note 491 at 33. In Canada, the ethics committees of the Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynaecologists of Canada have published a document listing their recommendations on all medically assisted procreation technologies: see *Ethical Considerations of the New Reproductive Technologies* (Toronto: Ribosome Communications, 1990).

502. Knoppers and Sloss, *supra*, note 269 at 669 n. 3, and the reports quoted therein.

503. Conseil d'État, *Sciences de la vie: De l'éthique au droit*, 2d ed. (Paris: La Documentation française, 1988) at 122-23.

504. Ministère de la Santé et des Services sociaux, *Rapport du Comité de travail sur les nouvelles technologies de reproduction humaine* (Quebec: The Department, 1988) at 152.

Without standards from their professional associations or regulations developed at another level, physicians are faced with a dilemma: in dealing with medically assisted procreation, should they simply meet the demand, or should they instead question the values involved, consider the common good and exercise their own judgment?[505] Leaving health professionals alone to set the ground rules in so complex a field puts a very heavy burden on them.

2. Local Ethics Committees

There are presently two major types of hospital or institutional ethics committees — research ethics committees and clinical ethics committees — and each type has a role to play in medically assisted procreation. Rather than give a complete background, we will simply state briefly that research ethics committees have been mandatory in Canada since 1978 for any research funded by the Medical Research Council of Canada: before a project is submitted to the Council, it must be approved by a local committee in accordance with the Council's general criteria.[506] Multidisciplinary committees are desirable but not mandatory; in some institutions, the committee is made up entirely of scientists. The main objective of research ethics is also to protect subjects in terms of both the inviolability of the person and the right to privacy. The Medical Research Council has issued special guidelines for research on embryos.[507] The guidelines are extremely important because in most centres the use of in vitro fertilization produces surplus embryos. This raises a number of questions about embryos that will not be given to another infertile couple, among them storage, experimentation, destruction and *ex utero* development.

Since research on the treatment of infertility is costly and is for the most part funded by official agencies, ethical controls are generally applied. However, these controls are not always entirely successful: the local approval process is not always as thorough as it should be, and there is much criticism of the lack of project follow-up once initial approval has been obtained. What is more, when the research is carried out by a private company the controls do not apply.[508] In addition, the controls no longer come into play once the technology is past the experimental stage. In effect, most medically assisted procreation technologies can now be used in fertility clinics and would therefore fall under the jurisdiction of *clinical* ethics committees.

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505. Guy Durand, "La bioéthique est une des principales préoccupations de la profession médicale" (1987) 116:6 L'Union médicale du Canada 343 at 350. See also Charles H. Baron, "Fetal Research: The Question in the States" (1985) 15:2 Hast. Cent. Rep. 12 at 15.

506. See Jean-Louis Baudouin, Monique Ouellette and Patrick A. Molinari, *Toward a Canadian Advisory Council on Biomedical Ethics*, Study Paper (Ottawa: Law Reform Commission of Canada, 1990) at 13ff.

507. Medical Research Council of Canada, *Guidelines on Research Involving Human Subjects* (Ottawa: Supply and Services Canada, 1987) at 33-34. Most of the papers, reports and recommendations mentioned in this working paper consider this aspect as well. See also *Biomedical Experimentation Involving Human Subjects, supra,* note 7.

508. The standards of the Medical Research Council of Canada can nevertheless be applied by hospital ethics committees when they consider research projects funded by the private sector.

The number of clinical ethics committees around the world has grown astronomically over the past ten years, and much has been written about them.[509] These multidisciplinary bodies are generally able to address the problems referred to them from a much broader perspective. Their role is essentially an advisory one. In 1986, the Canadian Hospital Association recommended the creation of ethics committees in all major hospitals.[510]

Clinical ethics committees are usually consulted when the attending physician feels he or she has a difficult decision to make or when there is a disagreement with the family or the medical team. But unless the institution has internal regulations requiring consultation in specific cases, the attending physician is free to treat patients for infertility as he or she sees fit; in other words, the physician can decide according to his or her own professional judgment to use medically assisted procreation technologies as soon as they are past the experimental stage. It should therefore come as no surprise that the criteria for using the technologies vary considerably.

In France, the centres for the study and storage of human sperm, or CÉCOS, have endeavoured to draft a common ethics policy. [TRANSLATION] "It became clear that the problems encountered were more than merely technical and demanded consideration of the very nature of artificial procreation through gamete donation, the significance of and rationale for the procedure, the inherent risks and the limits to be imposed."[511] However, this policy applies only to frozen sperm, not fresh sperm, which physicians remain free to use as they wish.[512] These regulations can also be circumvented by consulting private gynecologists.[513] Opinion is also divided on the issue of compensation. The Quebec departmental task force[514] points out that each clinic has its own rules.

Local committees still have undeniable advantages: apart from playing a role in education, as discussed above, they have very flexible operating structures and, with the proper membership, can be used to take the pulse of society.[515] The ethical rules that emerge can in the medium term provide inspiration for lawmakers. However, as has been noted,[516] they are but a temporary substitute for legislative intervention because they are not of any real effect unless they are accepted by patients. In disputes, they cannot be used as a basis for a court ruling unless they have somehow been incorporated in a statute or in regulations.[517]

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509. Baudouin, Ouellette and Molinari, *supra*, note 506 at 7.

510. Durand, *supra*, note 505 at 353; and Baudouin, Ouellette and Molinari, *supra*, note 506 at 7.

511. P. Jalbert and G. David, "Problèmes génétiques liés à la procréation artificielle par don de gamètes: solutions adoptées par les CECOS" (1987) 16 J. Gynecol. Obstetr. Biol. Reprod. 547 at 548.

512. Rubellin-Devichi, *supra*, note 314 at 460; Alain Sériaux, "Droit naturel et procréation artificielle : quelle jurisprudence?" *D.* 1985, 53 at 54, no. 4.

513. Jacqueline Rubellin-Devichi, "Le droit, les pères et la parernité" (1988) 24:3 Rev. Droit sanit. et soc. 425 at 435.

514. Ministère de la Santé et des Services sociaux, *supra*, note 504 at 107ff.

515. This is even more true of national committees: LeRoy Walters, "Ethics and New Reproductive Technologies: An International Review of Committee Statements" (1987) 17:3 (Supp.) Hast. Cent. Rep. 3.

516. Dominique Thouvenin, "Éthique et droit en matière biomédicale" *D.* 1985, 21 at 24-25, nos 12-13.

517. *Ibid.* at 23, no. 7.

Codes of ethics typically impose nothing more than minimum standards, and in dealing with patients, physicians must take into account their interests and their wishes. Ethical rules alone are not sufficient to deal with the problems raised by medically assisted procreation technologies.[518]

C. Community Control

1. Permanent Provincial or National Ethics Committees

Reference was made above to the regulations currently in place governing research. The need to regulate experimentation became apparent at the end of World War II, when it was discovered that horrifying experiments had been conducted without regard for the human subjects of them, on the grounds that the pursuit of knowledge justified whatever means might be used. Research ethics committees are in a position to impose rules because of their role in determining funding. Before issuing regulations, they normally consult broadly with the parties directly involved and with the general public. Their activities do not seem to give rise to opposition.[519]

When it comes to dealing not with research, that is, the acquisition of new knowledge, but rather with the application of that knowledge, ethical issues take on a very strong social dimension. For this reason, a number of authors and reports propose the creation of a national ethics committee where one does not already exist.[520] The American Fertility Society has also emphasized the need for national consultation. Gorovitz writes that "we need an independent agency of reflection and recommendation that is respectful of the full range of sentiment on such matters, and at the same time has the freedom and courage to take the stands that seem most justified — in full awareness that any stand on these matters will draw opprobrium from some quarters."[521]

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518. Knoppers and Sloss, *supra*, note 269 at 671 n. 7 and the reports mentioned therein.

519. For an overview of the main committees, see Durand, *supra*, note 505 at 352; Robertson, *supra*, note 483 at 19. See also *Biomedical Experimentation Involving Human Subjects, supra*, note 7; and Baudouin, Ouellette and Molinari, *supra*, note 506.

520. Specifically, Council of Europe, P.A., 38th Sess., Pt II, *Texts Adopted, Recommendation 1046 (1986) on the Use of Human Embryos and Foetuses for Diagnostic, Scientific, Industrial and Commercial Purposes*, s. 14 vii [hereinafter *Recommendation 1046 (1986)*]; Warnock Report, *supra*, note 421; The Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (Melbourne: F.D. Atkinson Government Printer, 1984) (Chair: Louis Waller) [hereinafter Waller Report]; Federal Ministry of Justice, Federal Ministry of Research and Technology, *Report: Working Group on In Vitro Fertilisation, Genom Analysis and Gene Therapy* (Federal Republic of Germany: J. Schweitzer Verlag, 1985) (Chair: Ernst Benda) [hereinafter Benda Report]; Knoppers and Sloss, *supra*, note 269 at 670; Jacqueline A. Priest, "The Report of the Warnock Committee on Human Fertilisation and Embryology" (1985) 48 Mod. L. Rev. 73 at 74; Samuel Gorovitz, "Engineering Human Reproduction: A Challenge to Public Policy" (1985) 10 J. Med. Phil. 267 at 271. See also Baudouin, Ouellette and Molinari, *supra*, note 506.

521. Gorovitz, *supra*, note 520.

Without compelling authority, how can ethical choices be imposed on those with different views? More to the point, what can be done to prevent commercialization, the proponents of which do not see beyond the law of supply and demand? The protracted search for an unattainable consensus is allowing new technologies to develop uncontrolled. It reflects [TRANSLATION] "the disarray of a society which, lacking a clear direction, intends to rely on a committee of scholars. . . . Is it possible that the future will be one of ethical rather than political laws?"[522] And are we to see in this an abdication of public authority?

2. The Courts

In the absence of clear legislation, the courts are among the first public institutions we turn to for settling disputes. Reference to the courts brings fundamental issues to the attention of the public and sparks the debate that is needed for any form of action, including legislative action.[523] The publicity afforded such issues by the media enables the courts to play a role in increasing public awareness. "Public policy may be affected by litigation and media attention. This in turn may affect the legislative approach that is chosen."[524]

Existing laws do not deal specifically with medically assisted procreation.[525] Some, however, include provisions that may serve to govern a number of new situations. [TRANSLATION] "The concept of the interest of the child, an elastic concept open to a wide range of interpretations, has until now been used as the basis for decisions in cases involving new reproductive technologies and especially surrogate motherhood."[526]

However, the application of existing rules to deal with a situation not anticipated when such rules were developed, such as recourse to the principles of natural justice, is not without problems.

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522. Thouvenin, *supra*, note 516 at 26, no. 15.

523. Take, *e.g.*, the *Quinlan* case (70 N.J. 10 (1976)) referred to in Baudouin, Ouellette and Molinari, *supra*, note 506 at 7. See also the comments by the Supreme Court of New Jersey in *Baby M, supra*, note 302 at 1264.

524. Veronica L. Payne, "The Regulation of Surrogate Motherhood" (1987) 17 Fam. L. 178.

525. See *supra*, note 479.

526. Michèle Rivet, "Le rôle du juge et des parlements en matière de procréation assistée" (1990) 1:1 International Journal of Bioethics 49 at 52:

> [TRANSLATION]
> In the whole area of parentage, the shift that has come about from a 'social' truth to be protected to a 'biological' truth to be recognized has given greater place to some aspects of 'fictitious' or consensual truth. Now the trend is toward a 'psychological' truth that springs from the very notion of the interest of the child, as a person with legal existence. Our courts will no doubt still have to rule on claims of parentage and custody disputes between surrogate mothers who want to keep their children and biological fathers who claim the offspring, and they may then use this concept of the interest of the child.

See also *supra*, chap. 2.

For some of the issues raised by medically assisted procreation, the legislation now in place is of little use to the courts. This may lead the courts to avoid ruling on the fundamental questions underlying the disputes brought before them. This is what occurred, for example, in the *Parpalaix* case in France, where the judgment dealt only with the return of frozen sperm to the widow, while the real social and ethical issue was post mortem insemination.[527] Further, while the discretion granted to judges may prove beneficial to some parties in a dispute, it also creates tremendous disparity in court rulings. The result for those who are parties to court actions is uncertainty as to the outcome of the case.

The judicial route therefore has its limits and does not offer a comprehensive solution to the problems associated with medically assisted procreation.

D. Legislative and Regulatory Control

1. Legislative Control

To the extent that courts, ethics committees, professional associations and citizens' sense of personal responsibility are inadequate to ensure the desired control over all medically assisted procreation technologies or specific aspects of those technologies, legislative intervention, with all the necessary reservations and qualifications it implies, may be needed. It may be also needed to fill the gaps in positive law regarding some of the consequences of medically assisted procreation, including the parentage of children and control over gametes and embryos, in order to uniformize the situation in a given province or state, within a country or even internationally.[528] This approach may also be useful in examining the values of our society at a given point in history. There is not a single report or national committee that does not recommend some form of legislative intervention.[529]

Public education may make the general population more aware of the issues and make freedom of choice more informed. Professional control and ethical review will limit the risk of abuse in the application of the technologies involved. The courts, by definition, deal only with disputes brought before them, which represent only a small proportion of the number of cases of medically assisted procreation, even surrogacy.[530]

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527. *Supra*, note 202. See Jones, *supra*, note 147.

528. D.G. Dickman, "Social Values in a Brave New World: Toward a Public Policy Regarding Embryo Status and In Vitro Fertilization" (1985) 29 St. Louis U. L.J. 817; Robertson (1986), *supra*, note 381 at 952 n. 48; Gorovitz, *supra*, note 520 at 269 and 271; Sériaux, *supra*, note 512 at 54, no. 4; Knoppers and Sloss, *supra*, note 269 at 667ff.; Baudouin and Labrusse-Riou, *supra*, note 210 at 252.

529. See, *inter alia*, Warnock Report, *supra*, note 421; Benda Report, *supra*, note 520; Waller Report, *supra*, note 520; OLRC, *supra*, note 2; Ministère de la Santé et des Services sociaux, *supra*, note 504; Barreau du Québec, *supra*, note 3; and Conseil d'État, *supra*, note 503.

530. See in particular the studies on surrogacy in Canada: Margrit Eichler and Phebe Poole, "The Incidence of Preconception Contracts for the Production of Children among Canadians," Study prepared for the LRC, September 1988 [unpublished]; Ministère de la Santé et des Services sociaux, *supra*, note 504; Conseil du statut de la femme, *supra*, note 493; Alberta Advisory Council on Women's Issues, *supra*, note 493.

Social regulation and the emergence of non-statutory standards[531] have an undeniable impact. They bear witness to an interest and a sense of responsibility present in a growing number of individuals. But it must be remembered that legislative intervention, a last-resort means of control and sanction, is bound to create some stumbling blocks.

Some writers suggest that positive state law is not the way to control all these issues.[532] A law that is enacted and subsequently proves to be unenforceable risks being ignored, thereby missing its target altogether.[533] There are also fears that, despite appearances, legislation would not necessarily give everyone adequate protection.[534] Others point to the risk of passing legislation hastily under pressure from the courts, public opinion and the media[535] when there is still no consensus.[536]

Of course, it is important not to make a decision too swiftly. We must take the time to weight the pros and cons of legislative intervention, consider public opinion, define the ethical bases on which to act[537] and take pains to avoid dogmatism.

2. Regulation of Procedures

Legislative intervention may be sweeping or compartmentalized or may simply consist in regulatory control of practices. The proliferation of public and private centres in which medically assisted procreation technologies are applied obviously makes the task of applying controls more difficult, whether the controls are aimed at application standards, the quality of professional services or the cost of health care. Many reports therefore suggest that licences be issued to institutions and/or professionals providing procreation assistance services.[538] In England, according to the Warnock Committee, the licensing authority should have the power to set standards for professional practice and research on medically assisted procreation and advise the government on specific matters.[539] This same general

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531. Michèle Rivet, "Les nouvelles technologies de reproduction: les limites de la loi" in Gérald A. Beaudoin, ed., *Vues canadiennes et européennes des droits et libertés: Actes des Journées Strasbourgeoises 1988* (Cowansville, Que.: Yvon Blais, 1989) 443 at 449ff. See Rocher, *supra*, note 480; Jean-Guy Belley, "L'État et la régulation juridique des sociétés globales" (1986) 18 Sociologie et sociétés 11.

532. Rubellin-Devichi, *supra*, note 314 at 457-59 and n. 7; Gorovitz, *supra*, note 520 at 271.

533. Rubellin-Devichi, *supra*, note 314 at 457-59; Gorovitz, *supra*, note 520 at 271; Council for Science and Society, *Human Procreation: Ethical Aspects of the New Techniques* (Oxford: Oxford University Press, 1984) at 84, no. 8.6; Kidder, *supra*, note 9.

534. Hutton Brown *et al.*, "Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth" (1986) 39 Vand. L. Rev. 597 at 665.

535. Payne, *supra*, note 524 at 178.

536. OLRC, *supra*, note 2 at 124; Payne, *supra*, note 524 at 180; Rubellin-Devichi, *supra*, note 314 at 496; Ministère de la Santé et des Services sociaux, *supra*, note 504 at 140; Council for Science and Society, *supra*, note 533 at 84, no. 8.5. For a general discussion of the subject see Kidder, *supra*, note 9.

537. Payne, *supra*, note 524.

538. See *infra*, appendix A at 173.

539. Warnock Report, *supra*, note 421 at 75ff. The Benda Report, however, *supra*, note 520, holds the view that such standards should be set out in legislation.

approach has been adopted by some states in Australia.[540] In this context, professional associations are without question very much involved in setting standards in the public interest. For the Quebec task force, the responsible agency would be the Department of Health and Social Services, which would set up an evaluation team to visit institutions periodically.[541] France's Conseil d'État recommends a certification system in accordance with the law and subject to administrative sanctions (revocation of licence) or criminal sanctions (for directors) in the event of a violation, as well as civil liability.[542]

This type of regulation, which is inevitable if social service agencies are to take charge of infertility treatment, also makes it possible to guarantee uniform standards for all centres and therefore greater fairness to the public and more transparent practices.[543] It would not prevent local ethics committees from ruling on specific cases. This approach would also permit better management of all the data related to artificial procreation. The Council of Europe recommends the establishment of a registry of all duly certified and authorized centres.[544] The Ontario Law Reform Commission notes that the remoteness of centres may have an impact on accessibility; the Commission adds that this phenomenon is not unique to infertility treatment but holds for all types of fairly specialized health care.

II. The Role of the State and the Federal Government in the Reform Process

A. The Role of the State

Any legislative or state intervention in medically assisted procreation should be aimed at promoting values that society holds fundamental,[545] such as the right to privacy and procreative autonomy,[546] respect for the physical and mental integrity of patients,[547]

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540. See *infra*, appendix A at 198ff. Compare OLRC, *supra*, note 2 at 129 and 275ff.

541. Ministère de la Santé et des Services sociaux, *supra*, note 504 at 152.

542. Conseil d'État, *supra*, note 503 at 63-64, ss 9-12. The use of medically assisted procreation as provided for in the law must be under the supervision of the social security ministry: *ibid.* at 67, s. 53.

543. See Ministère de la Santé et des Services sociaux, *supra*, note 504 at 152; Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *supra*, note 491 at 30.

544. *Recommendation 1046 (1986)*, *supra*, note 520, s. 14 vi.

545. For France, see Catherine Labrusse-Riou, "Servitude, servitudes" in Bernard Edelman and Marie-Angèle Hermitte, eds, *L'Homme, la nature et le droit* (Paris: Christian Bourgois, 1988) 308 at 326, where she writes that [TRANSLATION] "if we wish to humanize life, then the role of public policy is, on the one hand, to recognize the human being as different from objects or from other living forms and, on the other, to protect the integrity, the dignity and the nature of individuals as subjects."

546. See *R.* v. *Jones*, *supra*, note 336 at 318-19 and *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, *supra*, note 486 at 63 (procreative liberty); *Crimes against the Foetus*, *supra*, note 7 at 39.

547. *R.* v. *Morgentaler*, *supra*, note 336 at 60-63.

equality,[548] the protection of life,[549] special protection of children and those who are otherwise unable to protect themselves or who are vulnerable to harm or exploitation by reason of incapacity.[550] Indeed, Canadian society tends to regard many of these values as fundamental rights that give legal content to the moral concept of human dignity.[551]

Such values and rights help define the various roles the state may play in medically assisted procreation. On the one hand, the rights to privacy, confidentiality and autonomy do not admit of burdensome or unwelcome governmental intrusion into reproductive choices. This view inspired former Prime Minister Trudeau's famous comment — "[t]he state has no place in the nation's bedrooms" — when, over two decades ago, the promotion of contraceptives, among other things, was decriminalized.[552] It also inspires impassioned arguments against state control of assisted procreation technologies and against state power to decide who may procreate.[553]

On the other hand, a societal commitment to children's interests and rights,[554] and to protecting those who cannot protect themselves, would seem to call for an active and supportive government role in advancing reproductive health and family life. This view helps legitimate laws that grant children born using medically assisted procreation access to confidential records for medical or genetic information essential to their health.

Between the polar extremes of the state as oppressor and the state as protector-liberator lies a spectrum of supportive roles the state may assume in fulfilling its democratic mandate respecting medically assisted procreation: namely, as dispute arbiter, health service provider, public financier, lawmaker, researcher, protector of public health, safety and

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548. See *Canadian Human Rights Act*, *supra*, note 454, s. 3, prohibiting discrimination, *inter alia*, on grounds of family or marital status, gender, disability; and s. 15 of the *Canadian Charter of Rights and Freedoms*, *supra*, note 10. For a consideration of federal government obligations under international law in preventing discrimination and promoting equality by virtue of its international treaty obligations, see *International Covenant on Civil and Political Rights*, 16 December 1966, Can. T.S. 1976 No. 47, 999 U.N.T.S. 171, s. 26.

549. See *R.* v. *Wetmore*, [1983] 2 S.C.R. 284 at 288-89; and *Labatt* v. *Attorney General of Canada*, [1980] 1 S.C.R. 914 at 932-34: the traditional ends of criminal law include protecting public security, health, morals; the Court discusses *Russell* v. *The Queen* (1882), 7 App. Cas. 829 (P.C.) and *Reference re Validity of Section 5(a) of the Dairy Industry Act*, [1949] S.C.R. 1. See also *R.* v. *Crown Zellerbach Canada Ltd.*, [1988] 1 S.C.R. 401 at 442, 447, concerning contrasting national health protection initiatives under the criminal law power and under the peace, order, and good government power.

550. See *E. (Mrs.)* v. *Eve*, *supra*, note 385.

551. See *Morgentaler*, *supra*, note 336 at 164-66.

552. John Robert Colombo, ed., *New Canadian Quotations* (Edmonton: Hurtig, 1987) at 311. See also S.C. 1968-69, c. 41, s. 13 (amending former s. 159(2)(*c*) — now s. 163(2)(*c*) — of the *Criminal Code*). The amending law, also incorporated into the federal *Food and Drugs Act*, *supra*, note 298, contains express provisions for the regulation of contraceptive devices.

553. Compare *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, *supra*, note 486; *Eve*, *supra*, note 385; *Skinner* v. *Oklahoma*, *supra*, note 369; and Aldous Huxley, *Brave New World* (London: Chatto & Windus, 1932).

554. See Martha Minow, "Rights for the Next Generation: A Feminist Approach to Children's Rights" (1986) 9 Harv. Women's L.J. 1 at 18. See also Landau, ed., *supra*, note 279.

human life, strong and benevolent defender and promoter of human rights, or mere administrator of birth records.[555] The precise roles are determined partly by historical and still evolving state roles in reproductive health, and partly by fundamental and evolving values that define and structure legal relations between the individual, the family and the state.[556]

Many of the values underlying these various state roles are given expression by local, regional and national governments. Thus, provincial and territorial governments may license and regulate fertility and sterility specialists and clinics, as they do midwives, obstetricians and hospitals. They might help provide and pay for artificial insemination and IVF services for their residents, as they do for surgical treatment of infertility. They might prohibit discrimination in the delivery of fertility services, as they do for adoption or hospital services.[557]

B. The Role of the Federal Government

The federal government derives its national health role and public responsibilities from the same value base. The value of protecting life, expressed constitutionally in the duty to protect Canadian public health and safety under the criminal law power,[558] underlies the federal responsibility for certifying the safety and efficacy of therapeutic agents that affect fertility and sterility. Thus, the federal government regulates prosthetic tubes used in reconstructive surgery of the fallopian tubes, as it does fertility drugs and condoms — the latter of which help prevent the spread of sexually transmitted diseases that cause sterility.[559] Such jurisdiction over safety issues — complemented by federal jurisdiction over interprovincial and international commerce — extends to regulating the import and export of reproductive tissues, drugs, and medical devices.[560]

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555. See Jones, *supra*, note 147 at 540 n. 75.

556. See Michael D.A. Freeman, *The State, the Law and the Family* (London: Sweet & Maxwell, 1984); and "Symposium: The Family, the State and the Law" (1985) 18:4 U. Mich. J.L. Ref.

557. See, *e.g.*, the Ontario *Human Rights Code, 1981, supra*, note 454, s. 1, which applies to services and facilities; *Peters* v. *University Hospital Board*, [1983] 5 W.W.R. 193 (Sask. C.A.).

558. Compare *Wetmore*, *supra*, note 549 at 288, 293 (federal *Food and Drugs Act* protection of national public safety and health based on the criminal law power) and *Quarantine Act*, R.S.C. 1985, c. Q-1, based on s. 91(11) and (27) of the *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3. For further discussion of the criminal law power, see François Chevrette and Herbert Marx, *Droit Constitutionnel* (Montreal: P.U.M., 1982) at 742-45; and Peter Hogg, *Constitutional Law of Canada*, 2d ed. (Toronto: Carswell, 1985) at 399-402.

559. See *Food and Drugs Act, supra*, note 298; federal licensing of the fertility drug clomiphene citrate was granted some 25 years ago (see *supra*, note 33).

560. For a discussion of federal import-export and quarantine duties under the *Food and Drugs Act, supra*, note 298, see *Procurement and Transfer of Human Tissues and Organs, supra*, note 250. In this regard, Agriculture Canada has for years administered a national health protection regime to govern the thousands of animal embryos and millions of semen doses that cross the border annually. See the *Animal Disease and Protection Regulations*, C.R.C. 1978, c. 296, ss 32, 50, 59, 84 and 115, adopted under the *Animal Disease and Protection Act*, R.S.C. 1985, c. A-11, recently replaced by the *Health of Animals Act*, S.C. 1990, c. 21, ss 2, 14, 16 and 19. These initiatives would seem to flow from the federal criminal law, quarantine, trade and commerce, and agricultural powers.

Similarly, the federal government promotes the values of liberty, autonomy and fairness by prohibiting unfair and misleading advertising of medical products and services.[561] This role has been demonstrated by recent U.S. government prosecutions for illegal, false advertising of IVF success rates.[562] Consistent with principles of informed decision making, such laws may help ensure that the Canadian consumer is not harmed, defrauded, or deceived in the purchase of infertility or sterility products and services. Moreover, the funding of infertility research by Health and Welfare Canada, the provision of infertility treatment to members of the Canadian Forces,[563] and the legal entitlement of employees to paid pregnancy and adoption leave[564] — rights predicated on the view that society should no longer place women in the position of having to choose prejudicially between family life and employment opportunities — all illustrate complementary avenues through which the federal government may actively promote reproductive health. Indeed, its obligations with respect to (a) protecting public health, safety, and human life-forms through its criminal law power, (b) regulating international and interprovincial trade through its trade and commerce and quarantine powers, (c) protecting and promoting the national interest by responding to pressing "national concerns," (d) protecting human rights through its *Charter* and human rights obligations, and (e) funding medical research and health services through its spending power — endow the federal government in the modern Canadian state with significant and diverse constitutional and legal bases for protecting reproductive health.[565]

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561. See *Food and Drugs Act*, *supra*, note 298, s. 3; and *R.* v. *Gregory* (1973), 11 C.P.R. (2d) 32 (C.S.P. Que.) (unsubstantiated, misleading health claims prosecuted under *Combines Investigation Act*, R.S.C. 1970, c. C-23). For recent commentary on the evolution of the criminal law and national trade and commerce bases of federal fair competition legislation, see Katherine E. Swinton, *The Supreme Court and Canadian Federalism* (Toronto: Carswell, 1990) at 141-46 and 296-300; Neil Finkelstein, "Constitutional Law — Division of Powers — Constitution Act, 1867, Section 91(2) — Validity of Section 31.1, Combines Investigation Act: *General Motors of Canada Limited* v. *City National Leasing*; *Quebec Ready Mix Inc.* v. *Rocois Construction Inc.*" (1989) 68 Can. Bar Rev. 802.

562. See Proposed Consent Agreement with Analysis to Aid Public Comment, 55 Fed. Reg. 37961-62 (1990); *Federal Trade Commission* v. *Jacobson* (18 May 1989), Virginia 89-0078-A (U.S. Dist. Ct) (enjoining IVF clinic from falsely representing likelihood of pregnancy).

563. Members of the Canadian Forces may receive, at the National Defence Medical Centre or affiliated hospitals, such fertility services as artificial insemination by husband/partner, fertility drugs, reversals of tubal ligations, reversals of vasectomies. Personal communication, Department of National Defence Canada, Office of the Surgeon General, 1990.

564. See *Unemployment Insurance Act*, R.S.C. 1985, c. U-1, ss 18, 20, as. am. S.C. 1990, c. 40, ss 12-14, (17 weeks benefits for pregnancy and adoption leave), discussed in *Brooks* v. *Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219. See also *Canada Labour Code*, R.S.C. 1985, c. L-2, s. 206, 17 weeks statutory pregnancy leave; and *Schachter* v. *Canada*, [1988] 3 F.C. 515 (seeking equivalent paternity leave); aff'd [1990] 2 F.C. 129 (C.A.), leave to appeal to Supreme Court of Canada granted; judgment pending.

565. On these constitutional bases, the federal government has already structured a number of relevant national safety, health protection, health services, and medical financing schemes through the *Food and Drugs Act* (*supra*, note 298), *Quarantine Act* (*supra*, note 558), *Canada Health Act* (R.S.C. 1985, c. C-6), *Department of National Health and Welfare Act* (R.S.C. 1985, c. N-10), *Combines Investigation Act* (R.S.C. 1985, c. C-34 (now the *Competition Act*)) and the *Medical Research Council Act* (R.S.C. 1985, c. M-4). See *supra*, notes 558-561 and *infra*, note 574. See also Andrée Lajoie, Patrick A. Molinari and Jean-Marie Auby, *Traité de Droit de la santé et des services sociaux* (Montreal: P.U.M., 1981) at 891-92.

Finally, the state may also play a critical — and perhaps the quintessentially democratic — role in fostering societal inquiry, debate, study, education and reflection on medically assisted procreation through public forums in which the whole range of viewpoints may be expressed.[566] The recently created Royal Commission on New Reproductive Technologies has been given the mandate to assist government authorities in fulfilling this role through its public hearings in some 20 locales in Canada.[567] Such public debate may influence private reproductive choices in that it makes possible a better understanding of the current implications and provides guidance for future applications of medically assisted procreation.

Indeed, these public processes and forums seem likely to serve as the foundation and catalyst for national consensus, standards and reform. The public pronouncements of prior Canadian royal commissions and the legal initiatives to which they gave rise, as well as more recent public pronouncements from similar bodies in Australia, France, and Denmark are evidence of this.[568] Compelling "national concerns" for which the federal government bears particular responsibilities[569] continue to grow in Canada over such issues as the necessity of guaranteeing minimal but rigorous screening of gamete donors to protect potential recipients' offspring and the public from transmissible diseases; the absence of minimal national requirements for the collection, processing, storage and interprovincial or international distribution of gametes;[570] the moral and legal status of frozen embryos;[571] the legal relation between anonymous gamete donors and resulting offspring;

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566. See Jones, *supra*, note 147 at 545.

567. See P.C. 1989-2150.

568. See *infra*, appendix A at 173, and P.C. Order-in-Council 1976-781 creating the Canadian Advisory Council on the Status of Women, following a recommendation of the *Report of the Royal Commission on the Status of Women in Canada* (Ottawa: Information Canada, 1970) at 389-92.

569. Some aspects of medically assisted procreation issues that have attained national dimensions may require uniform, national legislative solution(s), as demonstrated by an inability of some provinces to address issues in such a way as to avoid "grave consequences" to residents of other provinces. In considering whether a problem is of "national concern" and warrants redress under the federal government's "peace, order and good government" power, courts and lawmakers must ask whether the "national concern" presents the country with a single, distinct or somehow indivisible issue or problem that requires one national law. One test is whether provincial co-operation may realistically solve the problem, given the consequences that may flow from the failure of one province to co-operate. If the analysis reveals the need for one national law, federal intervention must still be reconcilable with the powers and responsibilities of the provinces. See *Crown Zellerbach Canada Ltd.*, *supra*, note 549 at 431-36; Swinton, *supra*, note 561 at 203-08; Hogg, *supra*, note 558 at 375; and Patrice Garant, "La théorie des dimensions nationales: la recherche et l'expérimentation bio-médicales," Paper prepared for the LRC, January 1990 [unpublished]. The doctrine has served as a basis for the federal creation of the national capital region in Ottawa and for federal regulation of radio, aeronautics, marine pollution, and narcotics. See *Crown Zellerbach Canada Ltd.*, *supra*, note 549 at 424-29, 452.

570. Such standards have been called for in Canada for 15 years. See British Columbia Royal Commission on Family and Children's Law, *supra*, note 470; and *Report on Human Sperm 1981*, *supra*, note 148.

571. Assuming that frozen surplus embryos should never be treated "as mere objects," what specific interests, rights or duties define their legal status in different contexts like death or divorce of the donors, or similar situations? See *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49; *Divorce Act, 1985*, *supra*, note 329, ss 2, 16; *In re Estates of Elsa and Mario Rios*, *supra*, note 204 (no inheritance rights for frozen embryos). See generally "Control over Gametes and Embryos," *supra* at 39.

the potential exploitation of children and women in surrogate motherhood arrangements; and the misleading but avoidable variations in the reporting of IVF success rates.[572] Whether it be because such issues may imperil health, safety and life, or contravene fundamental values and rights, or challenge competing visions of the modern family, they combine to make legal and public policy reforms inevitable in Canadian society.

If legal reforms are to remedy inadequacies in the law, they may begin to do so by minimizing current ambiguities. This may be achieved by better defining the rights, duties, and interests of those affected by medically assisted procreation and the protection they should be afforded. Of course, reasonable minds may differ over whether a particular allocation of rights and duties is fair. But a just allocation of rights, duties and interests should be the common goal in a democratic society. Reformers should also be guided by an active, creative consciousness of the role the law may play in responding to the human need for both freedom and dependency in the various relations between child, adult, family, community and state: "The goal for the future is to devise reforms that help people help themselves — reforms that acknowledge the public as well as private influences on and preconditions for human relationships."[573]

To instil these principles into the legislative reforms that must be carried out in the area of medically assisted procreation in Canada will require a concerted, sustained, imaginative effort by federal, provincial and territorial governments. The articulation of public policy and national medical and bioethical standards will, of course, also depend heavily on the private sector and various communities. How should the process go forward?

The Royal Commission on New Reproductive Technologies is a welcome beginning. Still, in many respects the melding of efforts and views may well require the kind of common vision that underlay the enactment of universal health insurance in Canada years ago. If the enactment of such laws fundamentally and positively altered the relationship between the individual, the hospital and the state in Canadian society, it was because there was a shared vision of individual well-being, social justice and a national "co-operative partnership."[574] Whether changes of that magnitude are in order remains to be seen.[575] Still, similarly co-operative federal-provincial initiatives have led to the Canadian Blood Committee's management of national blood policy, the recently created Canadian Coordinating Office of Health Technology Assessment,[576] and the role of national expert

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572. See *supra* at 13ff.

573. See Minow, *supra*, note 554 at 23.

574. See the preamble to the *Canada Health Act*, *supra*, note 565.

575. Much would seem to depend on societal consensus, even in the important and sensitive domain of national public policy, respecting the necessity, form, and content of laws and policies that express basis principles of justice in the area of procreation.

576. In this sense, the provision of medically assisted procreation services across Canada might be modeled, in part, on the provision of blood transfusion services. Canadians entering hospitals who are in need of blood may currently rely on three levels of federal-provincial co-operation. First, the hospital or clinic that a patient enters is likely to be licensed and regulated under provincial health facilities legislation. Second, to ensure the safety of the nation's blood supply, such clinics, hospitals, and blood banks across Canada must also comply with minimal federal standards on the collection, screening, processing, storage, shipping, and labeling of blood products. Third, the overall management and development of national blood policies and principles are overseen by the national Canadian Blood Committee. See *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

committees in developing Canadian environmental regulations.[577] Such co-operation has been recommended by the Ontario Law Reform Commission.[578] Perhaps a similar vision and similar partnership today would best enable law and policy makers to fashion as able and as just a response to the challenges of medically assisted procreation.

577. See *Canadian Environmental Protection Act*, S.C. 1988, c. 22, s. 6: "For the purpose of establishing a framework for national action and taking cooperative action in matters affecting the environment and for the purpose of avoiding conflict between, and duplication in, federal and provincial regulatory activity, the Minister shall, in cooperation with the governments of the provinces, establish a federal-provincial advisory committee to advise the Minister on (*a*) regulations proposed." See also *ibid.*, s. 34; and Environment Canada, *Canadian Environmental Protection Act: Report for the Period Ending March 1990* (Ottawa: Supply and Services Canada, 1990) at 11.

578. See OLRC, *supra*, note 2 at 275, 277, recs 2, 17.

CHAPTER FOUR

Recommendations

We have already concluded that leaving the application of medically assisted procreation technologies to individual initiative entails too many risks and that the alternatives cannot ensure adequate control of the various aspects of assisted procreation.[579] We must therefore consider the appropriateness of legislative intervention.

Ensuring respect for the fundamental values of society,[580] protecting the public against risks that they cannot protect themselves against, and drafting statutes and principles of law that are capable of resolving potential disputes are, in our opinion, the main considerations that should inform legislative intervention.

The Commission is aware that provincial law has a very important role to play in medically assisted procreation. However, we feel it is essential to deal with the issue on a national scale and to take a comprehensive approach. The recommendations we present in this chapter reflect this view. Since medically assisted procreation raises issues of principle and practice that are of national interest, consistency in the policies adopted is very important. We will also have to consider the appropriateness of and need for a central agency to implement and ensure compliance with these policies throughout the country.

Before dealing with specific issues, we should point out that there are fundamental objections to the use of any or all medically assisted procreation technologies. Some hold that the technologies dehumanize procreation, go against nature and pose a threat to maternity and paternity, which, in this view, cannot be separated from the procreative aspect of sexuality.[581] Further, the use of third-party donations raises concerns about the

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579. See chap. 3.

580. *Crimes against the Foetus*, *supra*, note 7 at 32. *Ibid.* at 31:

> As observed earlier, such principles cannot be found simply by reliance on market research or religious doctrine. In our view, they can only be discovered by reference to our fundamental social values. Such values, we contended in *Our Criminal Law*, are of two kinds. Some are essential to the very existence of society, some to the existence of our own particular society in its present shape and form.

Included in the first category of values are respect for life and the inviolability of the person; included in the second are justice, equality, dignity and individual freedom. See LRC, *Our Criminal Law*, Report 3 (Ottawa: Supply and Services Canada, 1976) at 20-21.

581. See Pope Pius XII, *Discourse to Those Taking Part in the 26th Congress of the Italian Society of Urology*, 8 October 1953: AAS 45(1953) 678; and, more recently, Congregation for the Doctrine of the Faith, *supra*, note 490.

adverse psychological impact on the child and the infertile partner that may result from involving a third person in the make-up of a family unit.[582] As noted earlier,[583] the legitimacy of gamete donation also raises a number of questions. Does it not constitute a [TRANSLATION] "shift in the order of family relationships"?[584] Finally, there are those who maintain that the human embryo must be treated with the same respect and afforded the same protection as the person. They believe it should be forbidden to freeze, destroy[585] or experiment on embryos. Does this not mean that one might go so far as to oppose the creation of surplus embryos?

Still, there is no denying that these medical technologies do exist and that, in cases where natural procreation is impossible or undesirable, there may be moral grounds to justify the development and use of technologies to remedy infertility problems.

It is nevertheless essential that our society continue to question how human embryos and gametes should be treated and what value should be placed on them. In the field of medically assisted procreation, the issues must be weighed within the context of current medical knowledge so that the implications of a decision may be considered. Prohibiting the creation of surplus embryos, for example, would affect the safety of women participating in IVF programs. With each new cycle, these women would have to face the risks and inconvenience of superovulation and egg retrieval, and would have to agree to the transfer of a larger number of embryos and accept the accompanying risks.[586]

The issues must also be considered as part of an ongoing debate because the development of a policy on these important matters calls for education and discussion on a suitably advanced level. We therefore cannot claim to offer in this paper a definitive answer to this social dilemma. Our objectives are to contribute to the debate and to take the current situation into account in an effort to solve urgent problems. The Commission set out on this path by publishing the working papers *Crimes against the Foetus*[587] and *Biomedical Experimentation Involving Human Subjects*.[588]

On the strength of their potential for life and genotype, the Commission has already recognized gametes and embryos as having some moral value. First, it has argued that gametes and embryos should be distinguished from other human cells and tissues: "The first [gametes] are the virtual sources of new human life; the second [embryos] already

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582. The strongest objection to this procedure comes from the Vatican, which holds that recourse to the gametes of a third person "constitutes a violation of the reciprocal commitment of the spouses and a grave lack in regard to that essential property of marriage which is its unity." See Congregation for the Doctrine of the Faith, *supra*, note 490 at 24.

583. See *supra* at 46ff.

584. See Hermitte, *supra*, note 207 at 337.

585. One of the Vatican's objections to in vitro fertilization is based on the fact that it may involve the destruction of some embryos. Congregation for the Doctrine of the Faith, *supra*, note 490 at 18.

586. Especially since the technologies using the natural cycle are still in the experimental stage. See *supra* at 22.

587. *Supra*, note 7.

588. *Supra*, note 7.

have life."[589] Further, in the principles it stated and the limits it recommended in its working paper on experimentation, the Commission accorded the embryo intrinsic value.[590] For example, the Commission proposed that the creation of embryos solely for the purpose of scientific research be prohibited;[591] that the law never treat embryos as mere objects (indeed, the commercialization of embryos would be strictly forbidden); that experimentation be prohibited after the fourteenth day of embryo development; and that experimentation be authorized by a multidisciplinary ethics committee. The Commission also holds the view that the most appropriate way to dispose of surplus embryos resulting from in vitro fertilization is not to destroy them but to donate them to infertile couples or, failing that option, to use them for experimentation to advance knowledge.[592]

The protection afforded embryos is not, therefore, at odds with the creation, freezing or donation of surplus embryos. In fact, one of our recommendations specifically allowed for the freezing of embryos for a period of five years.[593] At this stage in our research, we believe that it is appropriate to reaffirm this position. We do not confirm their legitimacy, but we have no objection to the creation of surplus embryos or to the donation or freezing of gametes and embryos.

I. General Principles

Individual freedom, equality and human dignity[594] are some of the principles and values challenged and sometimes placed in conflict by the various issues associated with medically assisted procreation. Among these issues are access to technologies; the risks of a shift toward eugenic practices; the post mortem commercialization and use of gametes and embryos; and the phenomenon of surrogate motherhood. Meanwhile, the parentage of children born as a result of medically assisted procreation and control over gametes and embryos also raise problems in terms of the possible application by the courts of existing legislation and principles of law. Which values should prevail? What social choices should guide lawmakers? Are there acceptable compromises for Canadian society? What can be done to resolve disputes caused by these technologies? These are some of the questions that will be broached in this chapter.

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589. *Ibid.* at 53.

590. For the various legal conditions imposed on the validity of experimentation and the mechanisms proposed to ensure compliance with these principles, see *ibid.*, rec. 6 at 51.

591. The prohibition led to the recommendation of a criminal sanction: *ibid*, rec. 7(1) at 52.

592. *Ibid.* at 51: "[I]f circumstances do not permit donation, experimentation to advance knowledge seems to be preferable to outright destruction."

593. *Ibid.*, rec. 8(2) at 53.

594. See *Crimes against the Foetus*, *supra*, note 7.

A. Access

In a number of countries, discussion papers have proposed limiting, or legislation has limited, access to medically assisted procreation to stable heterosexual couples who are sterile or infertile or carry a transmissible genetic disorder. The interest of the child (often expressed as the child's right to have a father, a mother and a stable family) and society's interest in protecting the family unit, which is fundamental in our society, are the two arguments most commonly advanced to support such restrictions.

Before it can be determined whether it is necessary and appropriate to entrench such limits in legislation, the above-mentioned criteria must be analysed in terms of the individuals likely to request such medical assistance, and the other values, principles and interests that come into play. For the purposes of this analysis, we considered infertile or sterile persons (physiological infertility), persons who are unable or do not wish to procreate through sexual relations with the opposite sex (social infertility) and persons likely to transmit a genetic disorder (genetic infertility).[595]

Most of those who turn to medically assisted procreation are physiologically infertile. As a rule, the access criteria proposed for these individuals are that they be living as a heterosexual couple and that they be stable. The appropriateness of these criteria is not entirely clear. The criteria of heterosexuality and family status will be discussed later in connection with social infertility; our focus here will be on *stability.*

The criterion of stability, desirable though it may be, raises a number of questions. First, would it be fair to apply this criterion in cases of artificial insemination and in vitro fertilization when the stability of the couple or individual is not a factor in natural procreation, hormone treatment or surgery to correct infertility problems (other forms of medically assisted procreation)? While it is true that the use of gametes from a third person can cause special problems (disclosure of the child's origins and so on), we believe that the objective of using the stability criterion, that is, the welfare of the child, would be more easily attained by ensuring proper support before, during and after the child is conceived.[596] Second, this type of criterion is arbitrary and difficult to evaluate, and because it involves the application of non-medical criteria by health professionals it creates the risk of discrimination.[597] We

595. For the purposes of studying the limitations referred to above, we have to use a definition of infertility broader than the one used in the medical community (see *supra*, chap. 1). This approach is conceived to take into account not only the pathological but also the social aspect of infertility. See The National Bioethics Consultative Committee, *Discussion Paper on Access to Reproductive Technology* (Adelaide: The Committee, 1990) at 8: "Beliefs, social values, expectations and judgements all contribute to the social construction of infertility and to the way we value it and its alleviation."

596. See *infra* at 156-57.

597. See Benjamin Freedman, P.J. Taylor, Thomas Wonnacott and Katherine Hill, "Criteria for Parenting in Canada: A Comparative Survey of Adoption and Artificial Insemination Practices" (1988) 3 C.F.L.Q. 35. The article is the result of a study funded by the Strategic Grants Program in the Human Context of Science and Technology, Social Sciences and Humanities Research Council of Canada; see *ibid.* at 36-37.

therefore feel it would be inappropriate to include in legislation stability — or, for that matter, any other criterion based on parental aptitude — as one of the criteria for determining access to medically assisted procreation.[598]

The situation of people who are physiologically and genetically capable of procreating but for personal reasons cannot or do not wish to do so in the context of a heterosexual union poses a more difficult problem. These people fall into two categories: single people and homosexual people. Access to medically assisted procreation for these people raises the whole question of equality rights[599] as compared to protection of the child and the traditional family. It would be difficult for the state to consider any legislative limit on access to the various technologies used in medically assisted procreation without taking into account the spirit and letter of the *Canadian Charter of Rights and Freedoms*.[600] However, we need only consult various legislative provisions and recommendations made in other countries to see that the special situation of these individuals is rarely accepted as grounds for using medically assisted procreation. In fact many jurisdictions make access to medically assisted procreation conditional on physiological infertility, sterility or the existence of transmissible genetic disorders, or simply limit access to heterosexual couples.[601]

Making access to medically assisted procreation conditional on the existence of pathological conditions (sterility, physiological and genetic infertility) may seem normal, since the technologies were developed to circumvent these problems. However, we cannot ignore the fact that establishing such a condition with respect to artificial insemination[602] would deny access to single people and to homosexual people.[603]

Such limitations therefore raise the question of non-discriminatory access to available medical technologies. This means weighing a number of different interests: on the one hand, the interest of single people and homosexual people who express a desire to have children and to use the available technologies, as would infertile or sterile persons living as part of a heterosexual couple, to overcome the obstacles they face; and on the other, the interest of the child and society's interest in protecting the traditional family with two heterosexual parents.

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598. It should be noted, however, that some reports have taken the opposite position. See, *e.g.* OLRC, *supra*, note 2 at 275: "Eligibility to participate in an artificial conception programme should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions." The report of the Barreau du Québec, *supra*, note 3 at 36, recommends that access be limited to stable couples, married or unmarried. For more details, see appendix A, *infra* at 177.

599. See "Section 15 Equality Rights," *supra* at 92.

600. See *supra* at 82, 88ff, 90, 94 and 96-88.

601. See appendix A, *infra* at 177.

602. We have already stated that in vitro fertilization is different. Unlike artificial insemination, IVF and its derivatives are aimed primarily at female infertility. See *supra* at 98.

603. A legislative limit on access must not create disparity between the groups referred to in s. 15 of the *Charter* or analogous groups. See "Section 15 Equality Rights," *supra* at 92.

The conflict between respect for the rights guaranteed by the *Charter* and protection of the traditional family unit leads to a number of fundamental questions. How far do we wish to go in protecting rights and freedoms, especially the right to equality? How far do we wish to extend the definition of the family? Do we wish to include homosexual families and single-parent families in that definition?

For some, the interest of the child and society's interest in preserving families with two heterosexual parents must take precedence over the fundamental rights of single people and homosexual people. According to this position, having the freedom to choose one's sexual orientation is one thing, but depriving a child of a father and a mother is something else entirely. The technologies used in medically assisted procreation must be used to overcome sterility and infertility (physiological and genetic), not as an easy way out of the consequences of a social choice.

For others, who make the analogy with the criteria used in adoption, these objections are an expression of old prejudices.[604] Furthermore, through the years the state has not intervened to protect the traditional family, the structure of which has been greatly eroded.[605]

Resolving the issue of access to medically assisted procreation technologies thus requires a thorough examination of the family unit at the dawn of the twenty-first century. Are we prepared not only to accept single-parent families and families with two homosexual parents, but also to place them on an equal footing, in terms of our social values, with families with two heterosexual parents? If so, should we not, in the interest of consistency, change our family laws in order to incorporate these new definitions? Or do we wish instead to make protection of the traditional family a public interest that would take precedence over the rights and freedoms guaranteed by the *Charter* and thus limit the right to procreate as we limit the right to marry in our society?

In considering these questions, we could draw on similar situations in the area of "natural" procreation, where single-parent families and families with two homosexual parents are a reality.

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604. See *supra* at 96-98; and Knoppers, *supra*, note 284 at 216: "It is ironic that while adoption laws are being relaxed in order to permit unmarried individuals of either sex to adopt, social prejudices are preventing single women from having access to techniques that would enable them to bear and give birth to children that may in some cases be at least 50 per cent genetically their own." See also *supra*, notes 466 and 467.

605. A recent decision by the Federal Court of Appeal in a matter involving labour relations reversed a ruling by a federal human rights tribunal that in effect broadened the definition of family to include homosexual couples. The tribunal's ruling followed a complaint under the *Canadian Human Rights Act, supra*, note 454. See *Mossop, supra*, note 458 at 35: "Even if we were to accept that two homosexual lovers can constitute 'sociologically speaking' a sort of family, it is certainly not one which is now recognized by law as giving its members special rights and obligations."

For the moment, taking current social conditions into account, the Commission is of the opinion that with regard to artificial insemination, protection for the traditional family should not be incorporated in legislation at the expense of the right to equality.[606] Moreover, given the nature of artificial insemination, we believe that state intervention in this area should be kept to a minimum.[607] With respect to in vitro fertilization, the issue of the right to equality creates few problems.[608] However, since these technologies raise the question of the allocation of scarce and costly resources, a legislative limit on access could prove necessary. In any event, caution dictates that such action be taken in accordance with the principles of fundamental justice.[609]

Finally, the use of medically assisted procreation by persons who are physiologically capable of procreating but are carriers of a genetic disorder leads to the question of choosing which genetic disorders justify access to medically assisted procreation, and of which gametes and embryos should be considered "acceptable." There is a risk, in making such choices, of opening the door to eugenic practices. This concern also raises another issue, namely, the selection of donors or donor characteristics.

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606. In October 1988, the Spanish parliament passed a law on medically assisted procreation under which access is not limited to married couples. Single women and women cohabiting with men are eligible. See appendix A, *infra* at 177-78. OLRC, *supra*, note 2 at 157: "[A] majority of the Commission has come to the conclusion that, while participation in an artificial conception programme should not be a right given to every infertile or genetically diseased person or couple wishing to have a child, eligibility for participation should not be restricted to married couples or, indeed, even to couples." The OLRC states in its first recommendation (at 275) that the technologies should be used only for medical reasons, except in the case of single women who are fertile and genetically healthy. The report of the Ministère de la Santé et des Services sociaux, *supra*, note 504, s. 11, states at 176 that artificial insemination must be available to single women regardless of their status. Canadian Bar Association, *supra*, note 278 at 22: "After much discussion, the committee concluded that there was no need to legislate criteria of eligibility. While this might leave the situation open to personal prejudices of the treating physician, the committee further concluded that present legislation prohibiting discriminatory practices should provide sufficient protection." In Sweden, on the other hand, the technologies are available to married or cohabiting couples only, and the husband's consent is required; see appendix A, *infra* at 177-78, note 55. The Norwegian parliament has adopted a law regulating AI and IVF that limits access to married couples who have given their consent and have undergone a medical and psychosocial examination by a physician; see appendix A, *infra* at 177-78, note 56. Council of Europe, *Human Artificial Procreation* (Strasbourg: The Council, 1989) at 17:

> After careful examination of these arguments, realising the medical nature of these techniques and taking into account the importance of ensuring the welfare of the future child, the committee reached the conclusion that the availability of the artificial procreation techniques should be limited to heterosexual couples with a medical need. This determination intends to eliminate the cases where the future child would inevitably be born as an "orphan."

For more details about the position of other countries and states, see appendix A, *infra* at 177-78. For the reports that have limited access to infertile persons and persons at risk for transmitting genetic disorders to their children, see appendix A, *infra* at 178.

607. See *supra* at 90.

608. See *supra* at 98.

609. See *supra* at 89ff.

Using medically assisted procreation technologies to avoid transmitting a genetic predisposition or a characteristic trait that is deemed undesirable[610] or to choose the sex or select the desired qualities of the unborn child is unacceptable.[611] In more general terms, such practices lead the way to the development of a traffic in gametes and embryos with particular qualities,[612] breed intolerance of human imperfection and disrupt the demographic and social balance between the sexes for future generations, and could have a tremendous impact on these "made-to-measure" children. It therefore seems appropriate to generally limit individual freedoms in the name of respect for human dignity.

What genetic disorders justify the use of medically assisted procreation? This question can be answered indirectly by permitting the selection of gametes and embryos for specific qualities only in situations where the goal is to prevent the transmission of a serious genetic disease. Limiting the selection of donors and donor characteristics would also discourage unwarranted use of the available technologies.

It is one thing to allow the medical profession to address, as much as possible, the concerns of couples about the homogeneity of the family unit; it is quite another to allow couples to ask for particular donor characteristics or for the manipulation of gametes and embryos so that the child fits the stereotypes of society or satisfies the whims of the future parents, and the Commission is not prepared to recommend such a step.[613] It is therefore important that the description of the donor's characteristics be limited to essential details and that identification of the specific features of gametes and embryos be permitted solely to prevent the transmission of a serious genetic disease.[614] For example, it would be acceptable in cases where the purpose of sex determination would be to prevent the conception of a child with a sex-linked disease such as hemophilia.

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610. "Characteristic trait" is opposed here to serious genetic diseases such as Tay-Sachs disease, thalassemia, Duchenne muscular dystrophy, hemophilia and Huntington's disease.

611. C. Overall, "Introduction" in Overall, ed., *supra*, note 129, 1 at 18:

> A significant effect of reproductive technologies is that they seem to enable us to make more and more detailed specifications of what kinds of children we do and do not want to have. The apparently innocent goal, the positive goal, of having strong, healthy, thriving offspring, changes into a more negative goal of avoiding or getting rid of children with certain supposedly undesirable characteristics.

See appendix A, *infra* at 178-79.

612. The Repository for Germinal Choice in California, otherwise known as the "Nobel Prize sperm bank," is one example. See Arthur Caplan, "California Sperm Bank Is a Loony Notion" *The [Montreal] Gazette* (24 November 1989) B-3: "The bank claims to have deposits in its fridge from noteworthy scientists, some corporate success stories and at least one Olympic athlete. Nearly 100 babies have been created using sperm from the Repository for Germinal Choice. Couples who want to obtain sperm must be married and must show themselves to be persons of achievement and ability."

613. See appendix A, *infra* at 178-79.

614. See the report of the Ministère de la Santé et des Services sociaux, *supra*, note 504 at 65; see also appendix A, *infra* at 179.

In order to ensure compliance with these limits, the activities of banks and infertility clinics and the import of gametes and embryos must be controlled. And if they are to be effective, the limits must be applied uniformly throughout Canada.

RECOMMENDATIONS

1. Legislation governing access to medically assisted procreation technologies should respect the right to equality. Access should be limited only in terms of the cost and scarcity of resources. Where limitation is necessary, selection should not be based on unlawful grounds for discrimination within the meaning of federal and provincial legislation (family status, marital status, sexual orientation, and so on).

2. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited, except where the objective is to prevent the transmission of serious genetic diseases.

B. Commercialization

The existence of surplus embryos, and the donation, storage and import of gametes and embryos make the possibility that these genetic products may be considered objects of commerce[615] an attractive one. Society is thus forced to question the very nature of these products and consider a new definition of the person in law, namely, what can be deemed an object of commerce, or reified.[616]

Modern medicine has brought a new dimension[617] to the commercialization of the human body and its products and substances. The U.S. case of *Moore* v. *Regents of the*

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615. See *supra* at 40.

616. Bernard Keating, "Le statut moral de l'embryon humain: une approche attentive à la question des fondements de l'éthique," unpublished doctoral thesis, Quebec, Graduate School of Laval University, 1990 at 138-40:

> [TRANSLATION]
> Questioning the status of the human embryo means drawing a line between persons and things. This distinction is essential, as we dispose of things and respect persons. Things have a price; persons are priceless. To consider embryos as persons would be to acknowledge the limits of our ability to treat them as we see fit. It is established that a person can never be the mere means to an end. The stakes are very high. . . . Does accepting to treat human life, amid the obscurity of its origin, as an object not imply that a less than absolute respect for the person has already been accepted?

617. On the question of the commercialization of human organs, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

University of California[618] provides ample evidence of the complexity of the problems created by commercialization.[619]

The unique nature of gametes and embryos, as noted by the Uniform Law Conference of Canada, which excludes them from its definition of tissues,[620] raises a number of questions. While the nature and use of gametes and embryos raises issues pertaining to human dignity and leads us to reflect upon the moral or symbolic value to be accorded these genetic substances and upon the reification of the human being, the commercialization of gametes and embryos poses a similar problem of safety both for the woman in whom they are implanted and for the future child. Finally, commercialization has a bearing on freedom of commerce.

1. Embryos

Commercialization of the embryo must be prohibited outright for this purpose, as it should be for experimentation.[621] Treating the embryo as a thing that is an object of commerce and including it in the consumer market constitute a direct assault on human dignity.[622] But assuming that the embryo may be the object of a limited number of legal

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618. 249 Cal. Rptr. 494 at 498, 504 (Cal. App. 2d Dist. 1988):

> This appeal raises fundamental questions concerning a patient's right to the control of his or her own body, and whether the commercial exploitation of a patient's cells by medical care providers, without the patient's consent, gives rise to an action for damages. This appears to be a case of first impression. . . .
>
> We have approached this issue with caution. The evolution of civilization from slavery to freedom, from regarding people as chattels to recognition of the individual dignity of each person, necessitates prudence in attributing the qualities of property to human tissue. There is, however, a dramatic difference between having property rights in one's own body and being the property of another. . . . We are not called on to determine whether use of human tissue or body parts ought to be "gift based" or subject to a "free market." That question of policy must be determined by the Legislature. In the instant case, the cell-line has already been commercialized by defendants. We are presented a *fait accompli*, leaving only the question of who shares in the proceeds.

This ruling was partly upheld by 793 P. 2d 479 (Cal. 1990). The part of the ruling dealing with the general principle recognizing the patient's rights to control his or her own body was upheld. However, the principle was based merely on the doctrine of informed consent and the nature of the physician-patient relationship. For more details, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

619. Legal thought on the subject is developing rapidly at present, and the diversity of the solutions proposed is a clear sign that development must continue. For example, the theory of attribution put forward by Jean-Christophe Galloux in "De la nature juridique du matériel génétique ou la réification du corps humain et du vivant" (1989) 3 R. recherche jur. 1 at 1-31, implies an absolute but functional notion of the extra-commerciality of the human body. Hermitte concludes that a new category is needed and proposes the category of "things of human origin intended for human use." She subdivides products of the human body into "products that are not objects of commerce," "products that are not objects of exchange," "objects of remunerated exchange," "commodities," etc. See *supra*, note 207 at 325.

620. *Uniform Human Tissue Donation Act* (1989), *supra*, note 236; see *supra*, note 237. See also the opinion expressed by the Commission, *supra* at 122-23.

621. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49.

622. *Ibid.*

transactions, we must make certain that it does not become a commodity, at the mercy of the laws of supply and demand.[623]

2. Gametes

Making gametes mere objects of commerce may also violate the fundamental notion of human dignity. The specific nature of gametes (virtual sources of life) and the objective of gamete donation (allowing infertile people to become parents) are ill-suited to commerce in our society. The donation of gametes must remain an altruistic act. Moreover, competition between banks may lead to eugenic practices. For example, there is the risk of banks attracting and accepting only donors with certain qualities or characteristics that are deemed more desirable than others, thereby responding to a commercial stereotype of the ideal male parent.[624] To attain these objectives, a bank might, for example, pay a donor on the basis of his characteristics. Even if the couple were not allowed to determine what characteristics they wanted, the reputation of some banks for the "quality" of their donors could have the same result: a form of eugenics would be practised.[625]

Further, commercialization of gamete donation may compromise the "quality" of the gametes used. Monetary incentives increase the risk of donors failing to disclose some or all of the information needed to assess their suitability.[626] Moreover, the desire of banks to maximize their profits may have an adverse effect upon medical screening and selection.

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623. See Evelyne Shuster, "Seven Embryos in Search of Legitimacy" (1990) 53:6 Fertil. Steril. 975 at 977:

> [A] position most widely held is that embryos have only special or limited interests in life and thus should not be treated as actual persons with full moral rights. However, because they are potential persons, the embryos belong to the order of being and not of having. They are neither things nor properties. They cannot be bought, sold, or returned. Individuals do not have ownership rights to do whatever they want with them.

624. Council for Science and Society, *supra*, note 533 at 41-42:

> If commercial sperm banks were set up (as has already happened in the USA) this could give rise to some objectionable practices. Highly "desirable" donors might be tempted to sell their semen for large sums of money. Sperm from Nobel prize winners is already advertised in the USA, playing on people's desire to be parent to a genius and ignoring the adverse factor of sperm from ageing men.

625. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53-54: "The Commission is of the opinion that new recommendations concerning not only sperm banks but embryo banks as well should be drawn up, so as to establish clear and precise standards, and guard against the drawbacks and dangers of uncontrolled expansion and commercialization of such banks."

626. OLRC, *supra*, note 2 at 169:

> [W]e are also of the opinion that the need for a sound family history, and for information concerning whether a donor has contracted a sexually transmitted disease between the initial genetic screening and the donation, compels the conclusion that donors should not be induced to donate gametes by the lure of a reward, lest they suppress important information about themselves. The risk of such suppression, and its cost to those upon whom the burden will fall, outweigh any benefit achieved by permitting unrestricted payments.
>
> Accordingly, the Commission recommends that individual donors of sperm should be allowed to be paid their reasonable expenses.

See also *ibid.*, rec. 15 at 276.

Thus, the possible assault on human dignity and the risks inherent in commercialization warrant the limitation of individual freedoms, in particular, freedom of commerce. However, since people may not be willing to come forward unless their expenses are covered, reasonable expenses incurred by donors should be reimbursed.[627]

Finally, in view of the need to ensure optimum quality of genetic screening and selection, banks should be able to be reimbursed for reasonable costs related to their operations.[628]

RECOMMENDATION

3. (1) All commercialization of the donation of gametes and embryos should be prohibited. Only reimbursement of reasonable expenses incurred by donors should be permitted.

(2) Gamete and embryo banks should not be permitted to operate on a profit basis. However, banks should be allowed to be reimbursed for reasonable costs related to their operations.

C. Surrogacy

We must state at the outset that incidence of the phenomenon of surrogate motherhood is very difficult to evaluate. A study of surrogacy practices carried out in the summer of 1988 for the Law Reform Commission of Canada found:

> The major finding of this study is that preconception contracts involving Canadians are a phenomenon of very moderate scope but considerably more frequent than all of the people (with one exception) with whom we talked and who considered themselves knowledgeable in the area estimated. Taking our low overall estimate (i.e., allowing only 11 cases for Quebec) we end up with a grand total of 104 cases in Canada. Taking our higher estimate (allowing 25 cases for Quebec) we end up with a total of 118 cases.
>
> Either estimate greatly exceeds what was quoted to us as a reasonable estimate for the overall incidence. In order to appreciate this finding, it must be remembered that we have been extremely stringent in excluding cases if there was any doubt concerning them. We thus feel confident that these numbers represent a very conservative estimate which probably greatly underestimates the real extent of the phenomenon.

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627. In the same vein, see appendix A, *infra*, notes 65 and 66 at 179. See also *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.5; see *supra*, note 253.

628. See appendix A, *infra*, note 67. However, the OLRC report, *supra*, note 2 at 172, would allow banks to make some profit; see appendix A, *infra* at 180.

> We also conducted an analysis of socio-economic characteristics of contractual mothers, fathers, and fathers' wives utilizing Keane's agencies. Overall, contractual mothers belong to a lower social class than fathers and fathers' wives. It cannot be assumed that this analysis tells us anything about the participants in informal preconception contracts. We do not have sufficient information to make educated guesses about the socio-economic characteristics of this latter group of people.[629]

Even setting aside the contractual[630] and commercial aspects of surrogacy, the use of surrogates is the subject of much controversy. Uncertainty about the impact of the practice on the parties involved — especially the surrogate and, most of all, the child — raises major concerns about possible psychological risks.[631] While the use of a family member or friend as a surrogate may be less shocking to some, the risks remain. The relationship between the parties may even complicate the outcome. The child may also be exposed to significant physical risks if the surrogate, knowing she has to surrender the child at birth, acts in a negligent manner and fails to take the precautions needed to create the healthy environment that is vital to normal development of the fetus.

There are some who feel that, beyond these questions of safety, surrogacy contravenes the fundamental values of our society, in particular human dignity and the protection of the traditional family.[632] They argue that the use of a surrogate dehumanizes maternity, devalues gestation[633] and violates the child's right not to be treated as a thing that can be the subject-matter of a contract. Deliberately conceiving a child in order to surrender it to a third person at birth indicates a lack of respect for the unborn child and for life itself. Some argue in the name of these greater interests that individual freedoms should be limited and that surrogatehood in any form should be prohibited.

For others, the psychological risks, while they are serious, amount to nothing more than speculation, given the lack of knowledge about the true nature of the bond that is established during gestation.[634] This argument, therefore, cannot be used as grounds for

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629. Eichler and Poole, *supra*, note 530 at 45-46. The study shows very clearly, at least, that the phenomenon is shrouded in secrecy and extremely difficult to evaluate; an appendix includes a series of very interesting tables.

630. We saw in chap. 2 that, as the law currently stands, the contractual aspect of surrogate motherhood runs counter to the principles of contract law and family law; see "Legality and Legitimacy," *supra* at 65 and "The Enforceability of Surrogacy Contracts," *supra* at 84.

631. These arguments have been made by the OLRC, *supra*, note 2 at 230. See also Barreau du Québec, *supra*, note 3 at 28; and Warnock Report, *supra*, note 421 at 45.

632. See, *e.g.*, Barreau du Québec, *supra*, note 3 at 28. See also A.M. Capron and M.J. Radin, "Choosing Family Law over Contract as a Paradigm for Surrogate Motherhood" (1988) 16:1-2 Law Med. Health Care 34 at 36-37.

633. Baudouin and Labrusse-Riou, *supra*, note 210 at 111: [TRANSLATION] "Gestation is thus no longer a step in the establishment of a permanent mother-child relationship. It is reduced to a temporary function of production. It does not serve to create an emotional bond, but is used merely as a form of technical support." See Barreau du Québec, *supra*, note 3 at 29.

634. See OLRC, *supra*, note 2 at 231.

prohibition. The physical risks could be controlled by giving proper medical attention,[635] possibly mandatory, to the surrogate. Regarding the risks to the institution of the family, not everyone is convinced that surrogate motherhood represents an injurious infringement.[636]

We may not be in a position to assess the psychological impact of surrogate motherhood, but it does not take a comprehensive study to conclude that caution is needed. While control of surrogate motherhood may reduce the physical risks, regulation would imply state approval and the legitimization of surrogacy agreements.[637] As noted earlier,[638] endorsing surrogacy contracts would be at odds with a fundamental principle of family law: custody of a child must be determined according to the child's best interest and not the wishes of the parents as expressed in a contract.

The principle of human dignity leads us to conclude that a child cannot be the subject-matter of a contract and must under no circumstances be treated as a thing.[639] This principle should take precedence over individual freedoms. Treating a child in any other manner could change our perception of the human being. Provisions should perhaps be made at the national level to express this fundamental value in such a way that it cannot be challenged and to discourage all activity related to surrogate motherhood.[640] Accordingly, surrogacy agreements should not be recognized in law: they must remain absolutely null and void.[641] This conclusion is consistent with the existing principles of contract and

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635. *Ibid.*

636. *Ibid.* at 232. See Canadian Bar Association, *supra*, note 278 at 28: "The committee was not convinced that recognition of surrogacy agreements would undermine stability of the family."

637. See Warnock Report, *supra*, note 421 at 46-47.

638. See *supra*, note 630.

639. See *supra* at 40-41 and in particular note 209.

640. R. Alta Charo, "Reproductive Technologies and Bioethics in the United States: Looking Back, Looking Ahead" in Christian Byk, ed., *Artificial Procreation: The Present State of Ethics and Law* (Lyon: Lacassagne, 1989) 249 at 255: "In fact, following the controversial Baby M case, the legislative trend in the U.S. appeared to veer towards prohibition and away from the relatively supportive early state statutes in Arkansas, Kansas, and Nevada, which had regularized portions of the procedure without explicitly approving it or making the contracts enforceable." The New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (New York: The Task Force, 1988) at 127:

> Given the potential risks to the children born of surrogacy, children are best served by policies designed to discourage the practice.
>
> The Task Force members feel deep sympathy for infertile couples, many of whom experience a profound sense of loss and trauma. Nevertheless, the Task Force concluded that society should not support surrogacy as a solution. The practice will generate other social problems and harm that reach beyond the infertile couples who seek a surrogate arrangement.

641. Similarly, see appendix A, *infra* at 180-82, note 76, and table 4 at 210-13. However, Ontario (OLRC, *supra*, note 2 at 233) opted for regulation of surrogacy. The Canadian Bar Association (*supra*, note 278 at 29) commented as follows on the system proposed by the OLRC:

family law. The interest of the child must remain the basis for any decision respecting custody, and freedom of contract must be limited accordingly.[642]

The commercial aspect of surrogacy agreements raises various questions for society. For some, the idea that a woman might rent her womb is an affront to human dignity and integrity.[643] Others point to the possibility of disadvantaged women being exploited by women with economic power. Surrogacy agreements are also thought to be degrading for the child, who is exchanged for a sum of money and treated as a mere object of commerce. Putting a monetary value on a child is harmful not only to the child but also to society. The commercial aspect of surrogacy breaches a fundamental value: the human being is not an object of commerce.[644]

In terms of a regulatory scheme, the committee considered the approach recommended by the Ontario Law Reform Commission, which proposed a system of prior judicial screening and approval, as opposed to the traditional ex post facto review. The committee concluded that such a system was too cumbersome and likely not to be followed, even if legislated. It would establish a separate system for a type of assisted reproduction, something that should be avoided in principle unless good reason exists. The fact in these arrangements of deliberately creating a child for the purpose of surrendering its care to another is not sufficient distinction to warrant development of a unique approach and scheme. The committee has noted that most jurisdictions that have legislated in this area have maintained the traditional ex post facto review.

"Surrogacy" arrangements should be assimilated as much as possible into the existing model for adoptions.

The Canadian Bar Association, *ibid.* at 30 recommends "not to encourage surrogacy but to facilitate it in rare circumstances when the birth mother chooses to honour the agreement in a situation that gives every possible protection to herself."

642. See "Legality and Legitimacy," *supra* at 65 and "The Enforceability of Surrogacy Contracts," *supra* at 84.

643. See Warnock Report, *supra*, note 421 at 45.

644. This view is reflected in most jurisdictions around the world. See appendix A, *infra* at 180-82 and table 4 at 210-13. R. Alta Charo, "Surrogate Parenting: Analysis and Recommendations for Public Policy" (1989) 10:1 J. Leg. Med. 251 at 255: "The OTA report documents that commercial surrogacy has been disapproved in every governmental report in the world except that of the Ontario Law Reform Commission." In April 1990, The National Bioethics Consultative Committee in Australia released its first report on surrogate motherhood: The National Bioethics Consultative Committee, *Surrogacy, Report 1* (Adelaide: The Committee, 1990) at 36:

6.4 It is therefore recommended that:
(a) Surrogacy should not be totally prohibited.
(b) Surrogacy should not be freely allowed.
(c) Surrogacy practice should be strictly controlled by uniform legislation.
(d) Uniform legislation should include the following:
  (i) All surrogacy agreements be rendered unenforceable
  (ii) Controlling mechanisms for agencies
  (iii) Advertising controls.

See also The National Bioethics Consultative Committee, *Discussion Paper on Surrogacy 2 — Implementation* (Adelaide: The Committee, 1990).

Individual freedoms are often restricted in similar circumstances.[645] For example, adoption and child protection laws specifically prohibit the sale of children.[646] However, even if such provisions were applicable to children born of surrogates, they might not apply to the sale of children outside the context of adoption.[647] Because the existing provisions apply only where the transaction is intended to result in the adoption of a child,[648] if no petition for adoption is brought to establish parentage,[649] no one can be prosecuted. Further, even where a petition for adoption is filed, if the judge is not apprised of the fact that an exchange of money occurred previously, the transaction goes unpunished.

Prohibiting the sale of human beings is a fundamental value that, being a matter on which there is consensus, must influence the law. The role of lawmakers is to take action that at a given time unambiguously expresses society's values and views on such a fundamental issue.

The argument that surrogacy does not constitute the sale of a child but rather payment for a service does not withstand scrutiny because the intended result and purpose of the surrogacy agreement is to transfer custody of the child. In surrogacy, unlike in adoption, the child is conceived specifically to be surrendered in return for a sum of money. It should be remembered that the payment often represents more than the expenses incurred. Further, the role played by intermediaries and the fees they are paid emphasize the commercial aspect of the transaction. Even if the transaction were not the sale of a child, the result would be too much like a sale to be treated differently. Any attempt to commercialize

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645. Even those who advocate protection of the right to procreate generally feel that protection does not extend to the commercial aspect. See, *e.g.*, Charo, *supra*, note 310 at 108:

> As a commercial ban interferes only with an asserted right to pay for surrogacy, not with the right to procreate, and as women's self-reported motivations for becoming surrogates usually include non-commercial considerations, such as a desire to help other people, a commercial ban should be upheld as a rational expression of state interest that does not unduly interfere with the right to procreate. This conclusion is shared by at least two state courts.

It should be remembered that in *Baby M* (*supra*, note 302), the Supreme Court awarded custody of the child to the father of the child and granted visitation rights to the surrogate mother, but also ruled as follows:

> We invalidate the surrogacy contract because it conflicts with the law and public policy of this State. While we recognize the depth of the yearning of infertile couples to have their own children, we find the payment of money to a "surrogate" mother illegal, perhaps criminal, and potentially degrading to women. [at 1234] ... This is the sale of a child, or, at the very least, the sale of a mother's right to her child, the only mitigating factor being that one of the purchasers is the father. Almost every evil that prompted the prohibition on the payment of money in connection with adoptions exists here. [at 1248] ... In sum, the harmful consequences of this surrogacy arrangement appear to us all too palpable. In New Jersey the surrogate mother's agreement to sell her child is void. Its irrevocability infects the entire contract, as does the money that purports to buy it. [at 1258]

See also *Doe* v. *Kelley*, *supra*, note 310.

646. See *supra* at 67-69 and note 309.

647. See *supra* at 68.

648. Except for Manitoba; see *supra*, note 311.

649. See "Legal Parentage," *supra* at 69.

surrogacy (payment to surrogates and intermediaries) should be expressly prohibited. A recommendation to this effect would follow the logic of the prohibitions that currently apply to adoption and child protection.[650] Given the nature of such a prohibition and the need for uniform intervention, the Commission feels that the *Criminal Code* may be the right medium.[651]

However, while the commercial aspect of surrogate motherhood merits prohibition, the Commission feels that subjecting the infertile couple, who have already experienced the anguish of infertility, and the surrogate, who is trying to provide a solution to their problem, to the stigma of criminality and the ensuing consequences seems excessive and might still not dissuade couples who are only seeking to realize a legitimate desire. A criminal prohibition could drive the entire practice of surrogacy underground, with all the risks that entails.[652] Under-the-table agreements increase the possibility of irresponsible practice and make recourse to the courts virtually impossible because of the fear of reprisals. Such intervention could therefore prove very damaging for the child both physically and psychologically. Subjecting the parties immediately involved (the surrogate, her spouse and the social parents) to criminal prosecution could thus do more harm than good. Even if their actions are reprehensible, we are not convinced that it is appropriate to subject the parties to criminal proceedings. A total prohibition would not contribute adequately to the search for a solution to the problem and would not be warranted in terms of the principles of criminal law.[653] In any event, such a prohibition would certainly not be in the interest of the already-conceived child. Who should be given custody of the child once the parents have been prosecuted, found guilty and possibly imprisoned?

To ensure greater effectiveness in attaining the desired goal (preventing the development of a "child market" and discouraging people from engaging in traffic in children), the Commission is of the opinion that the *Criminal Code* should prohibit activity by paid intermediaries. Since paid intermediaries are the ones who create, set the conditions for and encourage such a market, discouraging people from engaging in activity of this nature would have a tremendous impact on the commercialization of surrogate motherhood. By not being subject to criminal sanctions, the immediate parties would be encouraged to lay charges against intermediaries. People would be dissuaded from engaging in such trade,

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650. See "Commercial Aspects of Surrogacy," *supra* at 67 and "The Enforceability of Surrogacy Contracts," *supra* at 84. It should be borne in mind, however, that Ontario and British Columbia permit some payments in adoption cases under certain conditions. In British Columbia, payment would be possible if it were authorized by a court of law; see *Adoption Act*, *supra*, note 309, s. 15.1. For Ontario, see *Child and Family Services Act, 1984*, *supra*, note 309.

651. *Our Criminal Law*, *supra*, note 580. As we have seen, however, current provisions of the *Criminal Code* do not cover the phenomenon adequately. See *supra* at 69.

652. Regarding obstacles to the effectiveness of legislative intervention, see Kidder, *supra*, note 9 at 112ff., at 117: "[S]udden legal changes don't always produce the results intended by the judges or lawmakers. ... Sometimes laws which were passed to produce one effect end up having either unintended side effects or opposite effects from those intended." On the phenomenon of those covered by a law changing the impact of that law, see in particular *ibid.* at 136-37.

653. See *Our Criminal Law*, *supra*, note 580 at 33.

as the risk to intermediaries would be too high: a conspiracy of silence would not protect them. Before becoming involved in such activities, intermediaries would have to consider the fact that they could well face charges (if, for example, the surrogate conducted herself improperly during the pregnancy, if she refused to surrender the child at birth, or if the social parents refused the child).

Preventing the commercialization of surrogate motherhood is a desirable objective, and if it is to be achieved legislative intervention is needed. However, consideration must be given to the real impact of such intervention and other equally important factors, such as the safety of the child. A total ban on surrogacy could give the impression that the problem was resolved, but this would not be the case. We believe it is more realistic and effective to stop only the activities of paid intermediaries than to try to prevent all surrogacy agreements between individuals. Such a position would bring Canada in line with the vast majority of the countries that have considered the matter.[654]

RECOMMENDATION

4. Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence.

The preceding recommendation is not unanimous. According to the minority view, it is both inappropriate and inefficient to criminalize only the remuneration of intermediaries in surrogacy arrangements. In the opinion of the minority, either of two alternative approaches would be more appropriate than that favoured by the majority.

The object of the proposed criminal prohibition is to stigmatize traffic in human beings. Commercialized surrogacy is seen by the majority as a form of trafficking in babies that should be prohibited. The situation is not really different from that in which people engage in the buying and selling of children already born. The anguish of infertility and the burden of carrying the child do not alter the reprehensible character of the activity. These factors may justify leniency in sentencing, but they do not exonerate the parents or the surrogate from criminal culpability. If the activity is considered sufficiently reprehensible to warrant criminal sanction, then the minority feel that, logically, all parties who engage in it should be subject to that sanction.

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654. Charo, *supra*, note 310 at 108. See, *e.g.*, the *Surrogacy Arrangements Act 1985*, *supra*, note 421, which prohibits surrogacy on a commercial basis and criminalizes the activities of specialized agencies or other third parties. The statute does not prohibit all forms of payment to the surrogate. The Warnock Report, *supra*, note 421 at 46-47, calls for sanctions for intermediaries and professionals, whether they operate for profit or on a non-profit basis. The United Kingdom White Paper does not share this view, however. Department of Health and Social Security, *Human Fertilisation and Embryology: A Framework for Legislation* (London: HMSO, 1987) para. 73 at 12: "The Government does not however consider that it is appropriate, nor necessarily in the child's best interests, to bring the practice of surrogacy other than the operation of commercial agencies within the scope of the criminal law and the Bill will not add to the criminal sanctions contained in the 1985 Act." For more details, see appendix A, *infra* at 180 and table 4 at 210-13.

According to the minority, however, simple refusal to accord legal recognition to any contractual arrangements relating to surrogacy would be more effective than criminal prohibition as a means of discouraging surrogate motherhood. All such contracts should be regarded as contrary to public policy and therefore be treated as void *ab initio*. If this were done, there would be two key consequences. First, there would be a presumption that the child is the natural child of the gestational mother. The social parents would have no recourse against her if she were unwilling to surrender the child. Second, intermediaries would not be able to collect any payment for the services they provide, and they could be compelled to refund any payment received. The risk of such an outcome would greatly discourage people from entering into any kind of surrogacy arrangement, especially one involving the payment of money. Such a regime could be supplemented by regulatory offences carrying substantial fines or other penalties. This would constitute an effective deterrent to anyone engaging in commercialized surrogacy.

D. Control over Gametes and Embryos

The question of control over genetic products and the limits to be imposed creates problems in terms of both application of existing legislation and principles of law, and respect for the fundamental principles and values of our society, in particular, individual freedoms and human dignity.[655]

The following remarks are made in a context where the technologies used in medically assisted procreation are not yet sufficiently advanced to prevent the creation of surplus embryos. In the long term, we can only hope that this problem will be resolved, but refusing to consider it today on the grounds of moral or ethical principles would in our view be unrealistic.[656]

Uncertainty about the fate of frozen gametes and embryos when, for example, a couple divorces or a dispute arises (whether between partners or between the bank and its clients) and about the nature of the producer's control over his or her gametes, as well as embryos created with them, has given rise to legal disputes for which the law as it currently stands offers no solution. Who has control? What is the basis for that control? In what way is the control restricted? And what limits apply to the way gametes and embryos can be used? Recent case law[657] indicates that the courts are quite embarrassed when asked to decide the fate of frozen gametes and embryos in circumstances of this nature. The rulings also bear witness to the difficulties and risks encountered when such disputes are left entirely to the judicial system. In the *Parpalaix* case,[658] for example, we saw that the central issue, namely the post-mortem use of gametes, was avoided. The ruling of the trial judge in

655. See Council of Europe, *supra*, note 606 at 11.

656. See *supra* at 122-23.

657. See *supra*, notes 202-204.

658. *Supra*, note 202.

the *Davis* case[659] in the United States illustrates the dangers of absolutism where the status of the embryo is concerned. Finally, it is difficult to accept that a couple should have to seek permission from the courts in order to be able to use their embryos for procreation.[660] The question of control over gametes and embryos therefore creates problems that demand a solution. What legal regime should apply?

1. Embryos

The nature of the embryo makes it difficult to determine its status (Is it a person or a thing?) and whether it falls into the private realm of property law or the public realm of the law of persons (who cannot be objects of commerce).[661] Given this impasse, how can the problem of control over the embryo be resolved?

A number of solutions are possible. The lawmaker could create a category for the embryo that would lie between things and persons; adopt rules of law that would borrow from both categories;[662] make the matter subject to the rules of property law;[663] impose a solution to any possible dispute (donation to third persons, destruction or experimentation) through regulation of banks;[664] or refrain from intervening but ensure that the consent of those with control makes provision for the fate of the embryos in specific situations.[665]

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659. *Supra*, note 203 at 2. Among the reasons for the decision by Judge Dale W. Young were the following: "(7) Human life begins at conception. (8) Mr. and Mrs. Davis have produced human beings, *in vitro*, to be known as their child or children." For a critical review of this position, see Shuster, *supra*, note 623 at 976ff.

660. *York* v. *Jones Institute*, *supra*, note 204. See *supra*, note 217.

661. See Keating, *supra*, note 616.

662. Catherine Labrusse-Riou, "Réflexions terminales" in Raphaël Draï and Michèle Harichaux, eds, *Bioéthique et droit* (Paris: P.U.F., 1988) 269 at 275: [TRANSLATION] "It is important that positive law preserve its categories of 'person' as opposed to 'thing', or the notion of civil identity defined by the category 'status of the person,' which cannot be disposed of; but within these categories, one should be imaginative in trying to find rules which themselves can change to accommodate these new situations we face." Louisiana recognizes fertilized ova as having "legal personality" until it is implanted in the uterus. As a "legal person," a fertilized ovum cannot, therefore, be considered property and could take or be the subject of legal action. The gamete donors are considered to be its parents; failing this, the medical clinic is designated the guardian of the conceptus. From this designation stems the prohibition against destroying an in vitro embryo that has the potential to develop normally. Although the conceptus has "legal personality" before it is implanted, its inheritance rights do not come into being until its birth and will be bound to the "natural" or adoptive parents (see appendix A, *infra* at 182). In France, the National Ethics Committee has termed the human embryo a "potential person" and therefore subject to the law of persons, not property. See Labrusse-Riou, *ibid.* at 273. Knoppers, *supra*, note 221 at 343ff. The article points out that the recommendations of U.S., European and Commonwealth law reform commissions indicate a consensus on the need to protect genetic material but do not necessarily grant it legal personality.

663. The intentions of the "owners" would prevail. Agreements so signed would have to be respected by divorce law and the law of successions. It would also be possible to make the contract of deposit binding.

664. See Conseil d'État, "Avant-Projet de Loi sur les sciences de la vie et les droits de l'Homme," 1989, s. 10 at 58 [unpublished]; see also appendix A, *infra* at 183. In the event of death, divorce or separation, the gametes would be destroyed.

665. The alternatives as to the fate of the embryos would obviously be limited by the possible use that can be made of them by the person with control in a given situation (expiry of the time limit on freezing, divorce, etc.); see *infra*, rec. 5(3).

Needless to say, leaving the question of control of the embryo to the rules of property law is entirely unethical,[666] but it also seems somewhat premature to suggest that legislatures create a new legal category for these potential living beings. Lawmakers must, however, develop special legal rules that will protect embryos but also permit the ethical debate to continue.[667] Such rules could be developed on the basis of the written, signed consent of the producers given before the embryos are conceived.[668]

While a written statement of consent before embryos are created allows the persons with control to set their terms for the creation of embryos, it is important that they be allowed to change their decision regarding the ultimate fate of the embryos before the embryos are used for the purpose for which they were intended.[669] Of course, in cases where control is shared by a couple, any change would require the consent of both partners.

RECOMMENDATION

5. (1) Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control, abandonment of the parental project, expiry of the time limit on freezing, or a divorce or other dispute between the persons with control. A person with control should be able to change, in writing, his or her stated intentions regarding the fate of the embryos as long as the embryos have not been used for their intended purpose; in cases where control over the embryos is shared by two people, both must agree to any changes.

But who should have control? In principle, control over an embryo should be based on both the genetic contribution and the intention of the parties, but what happens when these conflict?

When the embryos are the genetic product of a couple, the partners' interests are equal and also outweigh the potential interest of the bank or clinic that has the embryos in its possession. Thus, the embryos that resulted from the union of the couple's gametes should be jointly controlled by the couple, who alone should have the authority to decide the fate of surplus and frozen embryos. Implantation of any embryos should therefore first be agreed to by the couple. Consequently, the clinic or bank would have no right to keep the embryos or to go against the wishes of the couple in any way. Its only rights would be those expressly granted.

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666. The Commission has written that the law must never treat embryos or fetuses as mere objects. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49.

667. Regarding the important question of the status of the embryo, see Keating, *supra*, note 616.

668. See Shuster, *supra*, note 623 at 977. See also John A. Robertson, "Prior Agreements for Disposition of Frozen Embryos" (1990) 51 Ohio St. L.J. 407.

669. See *supra* at 52.

In cases where the embryos are partly the product of a donation from a third person, while it is clear that the donor cannot claim to have rights over the embryos,[670] there are questions regarding the status of the partner who has no genetic link to the embryos. While the wishes of each party have to be considered, the genetic link must give the partner whose gametes were used a greater interest than the other partner. In the event of a dispute over the fate of the embryos, the wishes of the genetically linked partner must prevail.

In cases where the embryos were conceived using donated sperm and eggs (that is, where embryos are not genetically linked to the future parents), control must rest with the bank or clinic that has the embryos in its possession.

RECOMMENDATION

5. (2) Control over embryos conceived using gametes from a couple should be exercised jointly by the partners. Control over embryos conceived using gametes from only one of the partners and a donor should vest in the partner genetically linked to the embryos. Control over embryos conceived with donated gametes should vest in the bank or clinic that has the embryos in its possession.

What is the scope of the control over embryos? What choices can the parties make in terms of disposing of the embryos? Is there a greater interest that would warrant imposing limits on the decisions a couple may make with regard to the disposition of embryos? The Commission has already expressed its opinion of the best way to dispose of surplus embryos; it would prefer that, rather than be destroyed, they be donated for implantation or, failing that, for experimentation. No solution is perfect: the response to those who in the name of a "parental plan" oppose donation could be that destruction is perhaps equally unacceptable. But what then?

It would be appropriate at this point to reaffirm the position we have taken: the person or persons with control may donate the embryos for implantation, donate them to science to be used within the stated limits, or have them destroyed.[671] Otherwise stated, the options for using embryos available to those who have control over them should be limited to implantation, experimentation and destruction.[672]

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670. We will later discuss the rights of donors over their gametes.

671. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 52; Robertson, *supra*, note 216 at 10: "The consensus emerging from the Ethics Advisory Board, the Warnock Committee, the American Fertility Society, and most other ethics commissions throughout the world that have studied the matter is that special respect for embryos does not require treating them as actual persons or prohibiting couples from opposing transfer." See also Robertson, *ibid.* at 10 n. 15.

672. See also Shuster, *supra*, note 623 at 977.

RECOMMENDATION

5. (3) The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing.

If the person with control decides to donate his or her embryos, it is important that he or she also state in writing the conditions he or she wishes to attach to the donation, that is, any conditions as to how the embryos may be used.[673] It is also important that the person be able to change the conditions or withdraw consent at any time before the embryos are used.[674]

RECOMMENDATION

5. (4) The person with control over an embryo who decides to donate the embryo should be required, before the donation is made, to make a written statement expressing his or her consent to the donation, and stating the conditions attached to the donation respecting the utilization of the embryo. That person should also be able to change those conditions or withdraw consent by making a written statement to that effect at any time before the donated embryo is used; in cases where control over the embryo is shared by two partners, both must agree to any change.

2. Gametes

Should we treat gametes differently than mere material property? This is a question that must be broached in the context of a broader consideration of the legal regime to be applied to the human body and its parts and substances.[675] The ultimate procreative purpose of genetic material further underlines the need for such a study. It goes without

673. See *supra* at 50-51.

674. See *supra* at 50-51. The possible conditions will be limited by the allowable use of the embryos by the persons with control; see *supra*, rec. 5(3).

675. Hermitte, *supra*, note 207 at 325. Hermitte suggests that the human body and parts and substances thereof fall into the category of "things of human origin intended for human use," between persons and things. Galloux, *supra*, note 619 at 3-4, 31, on the other hand, rules out the possibility of creating a category other than the categories of persons and things:

saying that gametes cannot be considered persons, yet designating them as things would be to ignore their specific nature.

As noted earlier,[676] the specific biological nature of spermatozoa and ova led the Commission to state that gametes and embryos cannot be considered simple cells or simple tissues.[677] Gametes are virtual sources of new human life and must be treated in a manner similar to embryos.

Control over gametes could be covered by private law but without being subject to the system of law reserved for things, and could also be governed by the intentions of the producer. A written statement of intent would assure persons depositing their gametes for storage that their right of control would be recognized and would make it possible to indicate the measures to be taken when, for example, the storage period expired or the persons no longer wished to use the stored gametes. Such consent would also allow persons donating their gametes to set conditions for using the gametes and to withdraw their consent before the gametes are used.

[TRANSLATION]
The division of the legal world into two distinct categories, things and persons, is a fact of life; without it, the law could not be. This *summa divisio* of the law has two corollaries: the categories of legal reality are specific and exclusive. They are specific in that they denote beings of a particular essence or nature, and they are contradictory: a being cannot be thing and person at the same time; it is impossible to shift from one category to the other unless the essence of the being is deprived of all permanence, and this the law does not allow. They are exclusive in that the law affords no room for a third category: this is simply the traditional application of the principle of the excluded middle accepted in our system of law. . . .

Genetic material, whether of animal, vegetable or human origin, and whether it is seen from a material or an informational perspective, is a thing. This view makes analysis of the legal problems created by genetics consistent with both scientific knowledge and our system of law based on specific categories. It confirms the fundamentally metabiological and unconventional nature of the person. Attributing personal qualities to human genetic material is tantamount to rupturing the fundamental unity of the living being and to giving persons and things circumstantial definitions the criterion for which would be embodiment. This somewhat irrational approach creates the risk of arbitrariness in law. It ultimately exposes the person to biological reductionism, the inevitable consequence of denying his or her metaphysical dimension.

Real qualification does not involve any devaluation of the living being. Nor does it imply appropriation or commerce: the fundamental categories of things communally owned and things that are not objects of commerce remind us of this. It does not deny the value of genetic material and the human body. Rather, it confirms the notion that value lies not in the nature of the thing, but in the intimacy and necessity of the bond between the thing and the person. It is therefore in terms of the legal regime of these "genetic things" that the law must promote the defence of the living being and the protection of the dignity of humankind.

Galloux does, however, use the notions of extracommerciality and attribution in order to limit legal commerce (legal action the purpose of which is to create, modify or extinguish rights) in products of the human body. See Galloux, *supra*, note 208.

676. See *supra* at 122-23.

677. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

RECOMMENDATION

6. (1) Control over gametes should vest in the producer.

(2) A person depositing his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes in such circumstances as the death of the person with control, abandonment of the parental project or expiry of the time limit on freezing. The depositor should be able to change, in writing, his or her stated intentions regarding the fate of the gametes before any embryos are created or the gametes are used for their intended purpose.

Where a producer donates his or her gametes, it is important that he or she state in writing the conditions he or she wishes to attach to the donation, that is, any instructions as to how the gametes may be used.[678] It is also important that the person be able to change the conditions or withdraw his or her consent.[679]

RECOMMENDATION

6. (3) A person who donates his or her gametes should be required, before the donation is made, to make a written statement expressing his or her consent to the donation and stating the conditions attached to his or her donation respecting the use of the gametes. The donor should be able to change these conditions or withdraw his or her consent by making a written statement to that effect at any time before embryos are created or the donated gametes are used.

(4) Possible uses of gametes should be limited to fertilization, experimentation and destruction; fertilization should be prohibited beyond the time limit on freezing.

3. Post-Mortem Use of Gametes and Embryos

Should we limit the possibility of using gametes and embryos following the death of the producers or one of the partners? Should we prohibit their use by the surviving partner? Should the definition of the family be extended to include post-mortem procreation? This raises the whole question of limits on individual freedoms and the force of contracts.

The answers to these questions may depend on the policies adopted regarding access to medically assisted procreation. Opting to protect the two-parent family would mean imposing a limit on freedom of contract. However, if no policy is adopted in an effort

678. See *supra* at 50-51. The options regarding the fate of gametes will of course be limited by the way the persons with control can use them; see *supra*, rec. 6(4). With respect to the time limit on freezing, see *infra*, rec. 12(2).

679. See *supra* at 50-51.

to protect the two-parent family, do we necessarily have to allow restitution to the surviving partner? Some will argue that the psychological problems such a situation may create, both for the surviving partner and for the child, cast doubt on the appropriateness of giving precedence to freedom of contract, and that caution would appear to be in order. For this reason, and given the very nature of the parental plan, it may be concluded that control over gametes and embryos in the event of the death of a producer should be limited to the following options: non-directed donation, experimentation or destruction.[680]

On the other hand, it may be objected that the phenomenon is still so new that it is difficult to raise any cogent arguments to justify restricting freedom in this regard. The Commission holds the view that the restitution of gametes or embryos to the surviving partner after the death of a producer should not be prohibited. Provisions dealing with parentage and succession in cases of post-mortem use will therefore have to be introduced.[681]

The Commission is aware that the solutions proposed in its recommendations on the control over gametes and embryos call for the exercise of provincial jurisdiction. Nevertheless, we felt it was desirable to state our position, as we believe it is essential to standardize the rules of law that will be needed to resolve these conflicts.

E. Parentage

1. Donation of Gametes and Embryos

The parentage of children born as a result of medically assisted procreation raises the issue of the possible application by the courts of existing legislation and principles of law. We have already seen that the current rules of legal parentage are inadequate in some new situations created by medically assisted procreation, and it is difficult to anticipate how they would apply in cases of dispute.[682]

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680. For example, the Council of Europe (*supra*, note 606 at 37) does not permit post-mortem use of gametes, citing the welfare of the child and the risk of break-up of the family unit. The Barreau du Québec (*supra*, note 3 at 24ff.) also recommends prohibiting such use because it deliberately creates an orphan and may cause serious psychological damage if the circumstances are disclosed. France prohibits post mortem use in the interest of preserving the two-parent family. See appendix A, *infra* at 186, in particular note 135.

681. In England, for instance, the post-mortem use of gametes by the surviving partner is neither prohibited nor encouraged. When they consent to the storage of their gametes and embryos, the couple is required to make provision for disposition in the event of death. If there are no specific instructions to this effect, the embryos will not be kept. Before implantation, the surviving partner must receive counselling. Australia holds the view that post-mortem use should be neither regulated nor prohibited. Spain permits post-mortem use if insemination takes place no later than six months after the death. The child is deemed the father's descendant only if he or she is recognized by the father in his will or in some other notarized document; otherwise there is no legal connection with the deceased. For the proposals of other countries and more details, see appendix A, *infra* at 186. Regarding the provisions on parentage and the law of successions, see *infra* at 187ff.

682. See *supra* at 56ff.

The main problems we identified as being associated with the donation of gametes and embryos included: the attribution of responsibilities arising from the paternity of a donor who has no wish to become a father; disavowal of a child whose conception was desired; the possibility of paternity challenges by third parties or a producer and a claim of paternity by the latter; the legal status of the child; and the division of maternity into gestational maternity and genetic maternity.[683] These problems lead us to consider the relative importance to be attached to the future parents' expressed intentions and to the biological and social criteria for paternity and maternity. However, the diversity of the rules governing parentage in Canada[684] shows that even in the area of natural procreation there is no clear answer. This makes the complexity of the problem even more evident and underscores the difficulty of finding a solution in the area of medically assisted procreation. Despite these difficulties, however, the Commission believes that some problems can no longer be eluded. Where donated gametes or embryos are used, parentage should reflect the intentions expressed by the parties at the time of the donation, namely the donor's wish to have no legal connection to the child,[685] and the desire of the couple or recipient to assume responsibility for the child.[686]

Parentage law must therefore provide: (1) the circumstances in which a presumption of paternity may be challenged; (2) that no bond of filiation can be established between a donor and the child; and (3) that any child born as a result of medically assisted procreation is deemed to be a legitimate child.[687]

RECOMMENDATION

7. (1) Provincial parentage laws should reflect the intentions of couples who use medically assisted procreation; accordingly, actions to disavow paternity by a father who gave his consent or to challenge paternity by a third party on the grounds that a donation from a third person was used should not be allowed.

(2) It should not be possible to establish a bond of parentage between a donor and the child.

(3) Legislation that still makes a distinction between legitimate and illegitimate children should recognize children born as a result of medically assisted procreation as having the status of legitimate children.

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683. We will see that this problem is of special significance in the area of surrogate motherhood; see *infra* at 148.

684. See *supra* at 57-58.

685. The Uniform Law Conference has reaffirmed that a sperm donor is not the father of a child born as a result of his donation and has no right or obligation to the child; see *An Act to amend the Uniform Child Status Act, supra*, note 199, s. 11.4(2); see *supra*, note 278.

686. *Ibid.*, s. 11.2.

687. *Ibid.*, ss 11.2 and 11.4.

Finally, since we propose that post-mortem fertilization with the gametes of a deceased partner not be prohibited, it is essential that new provisions dealing with inheritance rights be introduced. The Commission believes that children born as a result of assisted procreation should not inherit unless there is a specific reference to that effect in the will.[688]

RECOMMENDATION

8. Provincial succession laws should be harmonized to establish that children born as a result of the post-mortem use of gametes or embryos may not inherit unless there is a specific reference to that effect in the will of the deceased producer.

2. Surrogacy

Although surrogacy contracts are in all likelihood absolutely null and void under Canadian law as it stands at present,[689] the parentage of a child born under such a contract may be subject to contestation. The effect of the rule whereby the woman who gives birth is the legal mother is clear in cases where the surrogate is genetically linked to the child. She is both the genetic and the gestational mother. The social mother can rely only on her intent to become a parent. If the surrogate decides to keep the child, the dispute then becomes a question of custody and is settled by the courts in light of the interest of the child in the particular case.

However, the use of surrogates raises a new issue in law, namely the right of the social mother who is also genetically linked to the child to claim and prove her legal maternity, just as the genetic father could claim and prove paternity.[690] The interest in promoting sound application of the principles and rules of existing law thus comes up against the conflict between the interests of the gestational mother, the genetic mother and the child. The interest of the child in having clear parentage and a stable and loving family environment is not open to question. When maternity is divided among the genetic, gestational and social mothers, it is difficult to rule in favour of one or the other. Clearly, the link that is formed between the surrogate and the child during gestation is important and can hardly be compared to the link that may be established with the surrogate's husband during the pregnancy. It is therefore easier for the biological father to oppose his interest to that of the surrogate's husband than for the genetic mother to challenge the surrogate's interest. Yet we cannot ignore the interest of the genetic mother who attaches to her "donation" an expression of her intent to become a mother. Further, assessing the interest

688. For a similar view, see White Paper, *supra*, note 654, para. 60 at 10. For a general discussion, see appendix A, *infra* at 186.

689. See *supra* at 65-67.

690. It should be noted that this is not a right arising from the contract, since the contract is in all likelihood absolutely null and void, but rather a question of legal parentage.

of the child in having as a mother his or her gestational or genetic mother becomes an arbitrary exercise because we do not have the knowledge to make such a decision. Making such a choice now, even in the name of the child's stability, may be damaging in the long run.

We recognize the shortcomings of current law and the general interest in anticipating and resolving questions of parentage and the interest of the child in this context. However, we feel that it would be hasty to adopt just any rule to solve the problem of stability by choosing between gestational and genetic maternity.[691] Since experience and the existing rules are based on a different reality, namely the uniqueness and indivisibility of maternity, we cannot simply extend them to medically assisted procreation without more insight. We believe the fairest solution would be to let this new phenomenon unfold in the courts and in society before a rule is imposed.[692] At this stage, the interest of the child would be better protected by a court assessment of each case. The status quo leaves the door open to the judicial discretion that may be essential to the resolution of such disputes.

For these reasons, the rule whereby the woman who gives birth is necessarily the legal mother of the child should not, as it relates to surrogate motherhood, be entrenched in legislation.

II. Medically Assisted Procreation and Safety

Based on the preceding chapters, we can conclude that medically assisted procreation raises serious questions of safety for the people using the technologies and for the resulting children. Examples include problems related to low success rates; significant variation in the way such rates are calculated and interpreted; the physical and psychological risks; the lack of standards in record keeping; and the lack of national data.

A. Success Rates: The Importance of Informed Consent

The confusion surrounding the success rates of certain technologies leads us to question whether infertile couples are in a position to choose the option that is best for them.[693] Indeed, the different methods of reporting success rates[694] make interpretation very difficult, and yet an understanding of the rates is essential to informed consent.[695]

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691. See, however, *An Act to amend the Uniform Child Status Act*, *supra*, note 199; see also *supra*, note 325.

692. See *Anna J.* v. *Mark C.*, *supra*, note 324. Ms. Johnson was the first surrogate mother to claim parental rights to and custody of a child to which she was not genetically linked.

693. See *supra* at 5 and 13-15.

694. *Ibid.* Louise Vandelac, "La face cachée de la procréation artificielle" (1989) 213 La Recherche 1112 at 1114: [TRANSLATION] "Whereas in the public's mind the success rate of IVF and GIFT measures probability for each attempt to have a child, biomedical teams tend to view it simply as their own rate of success in certain phases of the process.

There are as many success rates are there are methods of calculation."

695. See *supra* at 62-63 regarding the need for free and informed consent.

In addition, the available success rates for artificial insemination are based on studies that for the most part were done when fresh sperm was being used.[696] These rates are therefore no longer conclusive because more recent studies have shown that the freezing of sperm, which is necessary today primarily to prevent the transmission of AIDS, reduces motility, longevity and ability to fertilize by half.[697] New studies should therefore be conducted to provide infertile couples with more realistic success rates.

In chapter 1, we demonstrated the complexity and lack of consistency in the way results are reported in the area of IVF and GIFT. Since success rates vary depending on the numerator and denominator chosen, it is not surprising to learn that the reported rates create confusion and do not make for easy comparison.

Given the very low success rates of IVF[698] and the vulnerability of infertile couples (for whom medically assisted procreation is often the last chance to conceive a child), it is essential that couples who choose this technology — as well as related procedures and GIFT — give free and informed consent. For this reason, clinics should be required to report actual results in a uniform manner, so that reliable statistics are readily accessible.[699]

To make possible a complete assessment of these results, it is therefore important that the content of clinical reports be standardized.[700] The statistics should show not only the number of pregnancies achieved or children born, but also the number of ectopic pregnancies, the number of spontaneous abortions, the number of embryos implanted, the rate of multiple pregnancy, the rate of birth defects and other possible problems.[701]

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696. See *supra* at 27.

697. *Ibid.*

698. See *supra* at 15-17.

699. We view this as a measured reaction compared with the proceedings recently taken by U.S. authorities against clinics that allegedly promoted their success rates unfairly and fraudulently. See Proposed Consent Agreement with Analysis to Aid Public Comment, *supra*, note 562; *Federal Trade Commission* v. *Jacobson*, *supra*, note 562. Compare *R.* v. *Gregory*, *supra*, note 561.

700. See *supra* at 15.

701. See *supra* at 17ff. On the subject of success rates and the need for national controls, Vandelac, *supra*, note 694 at 1116, writes as follows:

> [Translation]
> It is surprising that the notion of success rates is not homogeneously redefined in terms of the number of children conceived through IVF and healthy at the age of one month compared to the total number of superovulations. This would reduce the impact of multiple transfers in success rates and would lead to reconsideration of multiple transfers and IVF itself.
>
> Some reports, such as those by Australia, Wagner and the OMS, and the recent opinion by the Conseil du statut de la femme in Quebec tend to share this view and call for tighter regulation of artificial fertilization, as well as a redefinition of and greater transparency in statistics. However, public officials seem slow to react.

From another standpoint, analysing such data on a national basis would provide insight into the problems medically assisted procreation creates for our society and the people involved. The lack of uniformity in the methods used to report success rates and the general dearth of statistics are obstacles to proper evaluation of the current situation. We should require not only that the results obtained by clinics be reported uniformly, but also that the data be centralized and analysed on a national level. The standardization and centralization of data describing clinical activities and analysis of those data are essential because they make it possible to monitor practices. This could be done by establishing a national registry.

A confidential and voluntary national registry has already been set up by one group of health professionals. However, the very fact that the registry is voluntary creates major problems that make it virtually useless.[702]

To ensure that clinical reports are available, that the data are centralized, analysed and used to produce reliable statistical reports, and that the statistics can be accessed, clinics should be required to submit annual reports to a central registry managed by an administrative agency that we will discuss later. As stated earlier, these reports should include data on the use of all medically assisted procreation technologies, and a standard reporting method should be used; minimum content should be set and the presentation of data fixed. Statistical reports produced using the clinical reports should be available to the public.

RECOMMENDATION

9. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry; the minimum content of the reports should be set and the data should be presented in a prescribed form.

B. Risks

1. Physical Risks

The main risks associated with the use of gametes from a third person are the transmission of infectious or genetic diseases and consanguinity if the sperm of a particular donor is used too often.[703]

The risk of transmitting genetic and infectious diseases is greatly reduced if the donor is properly assessed and the gametes used are properly screened.[704] It is therefore important not only that standards for screening and selection be introduced, but also that they be applied consistently.

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702. See *supra* at 16-17.

703. See *supra*, note 163; see also *supra*, note 181.

704. See *supra* at 5, 26-27 and 32-33.

Unlike blood donations,[705] gamete and embryo donations are not currently subject to any national regulations,[706] yet the need for national standards was noted in one of the first Canadian reports on medically assisted procreation.[707] Further, a 1981 report to the Minister of National Health and Welfare on the storage and use of human sperm recommended that "[f]ederal regulations governing standards for the acquisition, preservation and importation of human sperm be established."[708] No legislative action was taken, however. All that has happened since is that a number of organizations have adopted guidelines.[709]

The uncertainty surrounding the application of uniform selection, screening and storage criteria makes it difficult to ensure the essential quality[710] of the gametes and embryos used in medically assisted procreation. Donor selection, screening of donations and storage conditions are important factors in the safety of both mothers and their children alike, as neither are able to protect themselves against these risks.[711]

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705. The *Food and Drugs Act*, *supra*, note 298, and its regulations set standards for, *inter alia*, advertising, labelling, sale, import, handling, storage and the number of donations permitted. The Canadian Red Cross Society also has standards in some of these areas. See *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

706. See *supra* at 64.

707. British Columbia Royal Commission on Family and Children's Law, *supra*, note 470 at 33:

> As an overall protection for all concerned, it is felt that the Health Protection Branch, Canada National Health and Welfare, should be responsible for the *establishment of standards* and for the surveillance of the safety of the whole operation of sperm collection, processing, storage, packaging and dispensing, just as they would for a pharmaceutical product.
>
> Because seminal fluid does not fall within the categories of foods, drugs, or devices which have been legislated as the mandate of the Health Protection Branch, a new legislation at the federal level would be required before such responsibilities can be vested within that agency [emphasis added].

Further, the final recommendation in the report reads:

> The Health Protection Branch, Health and Welfare, Canada, should be requested to take on responsibility for surveillance of human sperm banking, with associated collection, processing, distribution and documentation services. Appropriate *federal legislation* to provide this mandate should be proposed [emphasis added].

708. *Report on Human Sperm 1981*, *supra*, note 148 at xii.

709. See, *e.g.*, the Canadian Fertility and Andrology Society, *supra*, note 11. The Society's guidelines cover such matters as donor selection and genetic screening. However, see *supra*, note 300, and accompanying text. We stated *supra* at 32, that even though the merits of screening for infectious and genetic diseases have been widely discussed and advocated around the world, there is still concern that some clinics may choose not to follow such guidelines, as they have no legal force; see also *supra* at 64. Rona Achilles, "Donor Insemination: The Future of a Public Secret" in Overall, ed., *supra*, note 129, 105 at 111 writes as follows:

> The importance of screening sperm donors became particularly apparent with the advent of acquired immunodeficiency syndrome (AIDS). Several guidelines for screening of donors have been issued by medical associations. However, my own exploratory study, as well as a broader survey of U.S. physicians, indicated that most physicians did not follow the guidelines — only forty-four percent report testing for human immunodeficiency virus (HIV) antibodies.

The author refers to her own previous work, *The Social Meanings of Biological Ties: A Study of Participants in Artificial Insemination by Donor*, Doctoral Thesis, University of Toronto, 1986; Curie-Cohen, Luttrell and Shapiro, *supra*, note 282 at 585-90; and *Artificial Insemination: Practice in the United States*, *supra*, note 181 at 37.

710. The word "quality" is used in terms of safety, not eugenics.

711. Of course the various professional bodies and associations will have to be involved in developing these standards in the public interest.

RECOMMENDATION

10. Uniform and mandatory standards for the selection, screening and storage of gametes and embryos, and the selection and screening of donors, should be developed at the national level.

Since the use of fresh semen entails a considerable risk of transmitting diseases such as AIDS and screening must take into account the latency period of these diseases, it is important that donated sperm be frozen and that donors be properly screened.[712] The down side of such a policy is clear: clinics and banks have to wait some time before they can use donated sperm and are forced to repeat the required tests after each sperm donation. Further, such a policy completely rules out the possibility of using fresh semen for IVF, GIFT and AID, thereby reducing the success rate of these procedures. Despite these disadvantages, the Commission believes that clinics that use donated sperm in AI, IVF and GIFT must be required to use frozen sperm, and that clinics and banks that recruit donors must be required to test donors for the screening of the above-mentioned diseases.[713] These requirements are similar to those currently applied to blood donation.

RECOMMENDATION

11. Donated sperm should be frozen and should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus.

Freezing gametes and embryos creates certain problems, however. Science still does not know a great deal about the impact of prolonged cryopreservation, and the principle of generations may be completely altered because an embryo could in theory be reimplanted after a very lengthy period of freezing. These problems have led some countries to limit the length of time embryos and gametes may be frozen.[714]

The Commission recognizes that these limits are completely arbitrary[715] given the current level of expertise, but believes it is important from a safety and sociological standpoint to put a time limit on freezing. In setting the maximum freezing time, however, it is important to consider the fact that too strict a limit (for example, one that would allow embryos to be frozen for only a very brief period) would force women to deal with the risk and inconvenience of more frequent superovulation and egg retrieval or else the risk of having a larger number of embryos implanted per cycle. For the moment, the

712. See *supra* at 26-27 and 32-33.

713. See appendix A, *infra* at 191-92.

714. See appendix A, *infra*, table 3 at 207-209.

715. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

Commission reaffirms the five-year limit recommended in its working paper on experimentation.[716] However, the Commission would like to see more extensive research carried out nationally on time limits and, more specifically, on the effects of cryopreservation. The task of conducting the study could be given to a central agency which we will discuss later.

RECOMMENDATION

12. (1) Embryos should not be frozen for more than five years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this five-year limit.

Unlike embryos, gametes can be frozen even before a couple makes plans to have a child, because the reason for freezing may be the prospect of infertility in a person about to undergo medical treatment or surgery.[717] In light of this fact, we believe a limit of ten years is more appropriate.[718] The earlier comments regarding the need for more extensive research on the effects of cryopreservation apply here as well.

RECOMMENDATION

12. (2) Gametes should not be frozen for more than ten years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this ten-year limit.

To minimize the risk of consanguinity, it is also important that a limit be placed on the number of times gametes from the same donor may be used.[719]

However, since the risk depends on such factors as the density and mobility of the population served by the bank or clinic, it is important that the limit be flexible enough to take these factors into account. Studies will have to be conducted in this area.

RECOMMENDATION

13. A limit should be placed on the number of times gametes from the same donor may be used. Further, the studies needed to set an appropriate limit should be encouraged.

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716. *Ibid.* See also Act 35/1988, of November 22, on Techniques of Assisted Reproduction, s. 11 (Spain); Conseil d'État, *supra*, note 664; *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, s. 14; White Paper, *supra*, note 654 at 9; Canadian Bar Association, *supra*, note 278 at 33-37. For more details, see appendix A, *infra* at 191-92 and table 3 at 207-209.

717. See *supra* at 27.

718. See *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, ss 4, 14; White Paper, *supra*, note 654 at 9.

719. See *supra* at 28. In comparative law, see appendix A, *infra* at 192-93.

Finally, we have already indicated that some clinics import gametes from the United States.[720] The existence of international traffic in these products raises the question of whether the standards applied in other countries are sufficient. It is therefore essential to ensure that imported gametes and embryos also meet our national standards.[721]

RECOMMENDATION

14. The import of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should have to meet Canadian standards.

IVF and GIFT entail additional risks of their own, most of them resulting from superovulation and multiple pregnancies.[722] The rate of multiple pregnancy is of particular interest here because it raises the question of the appropriateness of limiting the number of embryos implanted or eggs fertilized per treatment cycle. We showed at the beginning of our study that transferring more than one embryo increases the chances of conceiving but also increases the possibility of multiple pregnancy. Given the high risks associated with multiple pregnancies,[723] a limit on the number of embryos implanted per cycle would seem to be in order.[724] It is not clear, however, that such a limit would help reduce the rate of multiple pregnancy. It should be remembered that the number of embryos transferred is not the only factor affecting the chances of conception and the chances of multiple pregnancy. We have already seen that transferring three embryos may in fact result in a higher rate of multiple pregnancy than transferring four.[725] It is therefore essential that greater importance be attached to the specific circumstances of each case (age of the woman, previous pregnancies, and so on). An arbitrary limit would not attain the desired goal, namely ensuring the safety of the mother and the unborn children.

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720. See *Report on Human Sperm 1981*, *supra*, note 148 at 13.

721. Some genetic products may fall within the scope of the *Food and Drugs Act*, *supra*, note 298. However, the uncertainty as to whether gametes and embryos are included and the need for specific standards mean that more direct intervention is needed. Regarding this matter and the application of the *Quarantine Act*, *supra*, note 558, s. 5, and the *Customs Tariff*, R.S.C. 1985, (3d Supp.), c. 41, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250. It is, to say the least, surprising that safety is carefully regulated in the area of animal genetic products, but there are no specific provisions dealing with human gametes and embryos. It is interesting to note that Canada last year exported more than 1,200 frozen animal embryos and 2 million doses of animal sperm under a national regulatory system. The system provides for the licensing of some 48 national services that transfer genetic material to be used for reproduction and requires permits to import and export fertilized and unfertilized gametes. Last June, Parliament updated this disease control system in the *Health of Animals Act* (*supra*, note 560). See *Animal Disease and Protection Regulations*, *supra*, note 560, ss 32, 50, 59, 84 and 115, administered by Agriculture Canada under the *Animal Disease and Protection Act*, replaced by the *Health of Animals Act*, *supra*, note 560, ss 2, 14, 16 and 19.

722. It was stated *supra* at 17, that the rates of spontaneous abortion, multiple pregnancy, ectopic pregnancy and Cesarean section are substantially higher than the rates observed in the general population.

723. See *supra* at 17ff.

724. See *supra* at 20. The Interim Licensing Authority in the United Kingdom and the Reproductive Technology Accreditation Committee in Australia have implemented recommendations limiting to three or, in extreme cases, four the number of embryos that may be implanted.

725. See *supra* at 20.

The development of technologies that use the normal cycle of ovulation, thus eliminating the risks associated with the drugs used in superovulation and reducing the risk of multiple pregnancy, is certainly to be encouraged. Pending more conclusive results, the primary focus must be to reduce the rate of multiple pregnancy.

RECOMMENDATION

15. Every effort should be made to reduce the risk of multiple pregnancy and to promote the development of technologies that follow the normal cycle of ovulation. Accordingly, the federal government should encourage studies and research aimed at reducing the multiple-pregnancy rate and developing technologies that follow the normal cycle of ovulation. Further, clinics should be required to document and justify the number of embryos implanted in each treatment cycle.

2. Psychological Risks

False hopes based on unrepresentative success rates, the consequences of high failure rates with some technologies, the psychological impact of the various stages in IVF and GIFT procedures, and genetic intervention by a third person represent significant psychological risks for people who decide to resort to medically assisted procreation.

Behind the low success rates lie the pain and anguish of couples for whom the process has failed.[726] Other sources of stress and anxiety are the high cost of some treatments, the physical demands placed on the person being treated and the different steps they entail.[727]

Finally, using a donation from a third person to form a family unit can also create psychological risks for the future parents and the child. The psychological stress of keeping such a secret, the consequences of unprepared disclosure, the possible frustration of the

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726. On the subject of success rates, Vandelac (*supra*, note 694 at 1115) writes: [TRANSLATION] "The success rate masks . . . the pain and anguish of those who have suffered miscarriages, ectopic pregnancies or stillbirths and had to deal with the accompanying risks, pain, dashed hopes, complications and hospitalization." Carolyn M. Mazure and Dorothy A. Greenfeld, "Psychological Studies of In Vitro Fertilization/Embryo Transfer Participants" (1989) 6:4 J. In Vitro Fert. Embryo Transfer 242 at 248: "The other most common emotional experience appears to be that of a grief reaction when treatment does not yield a pregnancy." See also *ibid.* at 250 on the same subject. Regarding the attitude and feelings generated by infertility, see *ibid.* at 243-44:

> Freeman *et al.* reported that in their pretreatment interviews of 200 IVF/ET couples, 49% of the women and 15% of the men considered infertility the most upsetting experience in their lives as compared with other serious losses such as death or interpersonal stressors such as divorce. Mahlstedt *et al.* asked IVF/ET participants to return questionnaires by mail at the end of a treatment cycle or when pregnancy status was known. In this study, participants were also asked to compare stress from infertility, death, and divorce. Of those who had experienced divorce or death of a close friend or family member, . . . 63% reported that infertility was as stressful or more stressful than divorce, and 58% reported infertility as stressful or more so than death of a loved one.

727. Mazure and Greenfeld, *supra*, note 726 at 248-49.

father with regard to the child and the mother (if she has a biological link with the child) and the identity problems the child may experience cannot be ignored. The need for support therefore goes beyond medical assistance in conceiving a child. Because people diagnosed as infertile (often after years of failure and investigation of the problem) are fragile and face difficult choices, they must be very well informed about what lies ahead for them. In order to be able to make a free and informed decision, it is important that the infertile couple be given the option of consulting experts (psychologists, physicians and others) at any time during and after medically assisted procreation technologies are used, regarding all of the risks, physical[728] and psychological, as well as the actual success rates. Clinics that offer medically assisted procreation services should therefore be required to provide counselling services.[729] We will come back to this question in our discussion of the certification of clinics.

RECOMMENDATION

16. Every clinic offering medically assisted procreation services should be required to provide to persons using medically assisted procreation, either before, during or after the application of a technology, counselling services whereby these persons could obtain from experts (psychologists, physicians and so on) the assistance and information they might need concerning the specific problems involved in medically assisted procreation.

C. Record Keeping

Proper medical records are not only essential in terms of regulation,[730] the compiling of statistics and the carrying out of studies on the long-term effects of various technologies, but may also prove extremely important in terms of the physical and psychological health of the child. Medical information about a child's genetic heritage may be needed to give the child optimum medical care. It is therefore essential that this information be kept and that it be accessible.[731]

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728. See *supra* at 17ff.

729. See *supra* at 23. In New South Wales, counselling is mandatory; see appendix A, *infra* at 193. Rec. 19 of the Warnock Report (*supra*, note 421 at 82) reads as follows: "Counselling should be available to all infertile couples and third parties at any stage of the treatment, both as an integral part of NHS [National Health Service] provision and in the private sector." The Ontario Medical Association guidelines (*supra*, note 85 at 28) include a general provision on the need for counselling services: "Special attention should be given to the emotional support and needs of couples and their families. For many couples, IVF is not appropriate treatment for their infertility. Counselling should, therefore, be available for all couples to provide a forum to discuss the alternatives to IVF."

730. Knoppers and Sloss, *supra*, note 269 at 681: "Linkage and tracing through complete and long-term record keeping are necessary to effectively regulate and evaluate the choice of gametes." Such control also makes it possible to trace contaminated gametes and the people who donated and received them.

731. See "The Right to Be Informed of One's Biological Origins," *supra* at 90. At 91 we stated that refusing to disclose information needed to protect life and health would be a violation of the right to security of the person conceived through medically assisted procreation. See also art. 583 of Bill 125, *supra*, note 196.

However, keeping such records and ensuring access to the information they contain raise the question of respect for the privacy of the parties, in particular their right to anonymity. Information about the identity of the parties should therefore be kept separate from the medical records, and clinics should set up a system that would enable physicians to link donors to recipients and thus to the children conceived using their donations. The system would ensure access to the necessary medical and genetic information but would not violate the right of the parties to privacy.[732] In view of this right, only information needed to attain the desired objectives should be collected, and clinics should be responsible for protecting the confidentiality of the information they hold.[733]

Yet identifying information[734] and social information[735] may have a bearing on the psychological well-being of the child. This raises the whole question of the right of the child to know the circumstances of his or her birth and the identity of his or her progenitors.[736] As stated above,[737] this is not an entirely new issue for us. In the area of adoption, some provinces have set up systems to enable adopted children to locate their biological parents.[738] It is recognized that searching for and finding one's biological parents, or at least knowing who they are, fills a major psychological need in children who are adopted, and an analogy can undoubtedly be made with children conceived as a result of a donation.

The interest a child may have in knowing the circumstances of his or her birth is, on the one hand, at odds with respect for the parents' privacy. Forcing the parents to disclose to the child information about his or her origins could be perceived as an unconstitutional infringement of the fundamental right of the parents to make the decisions that they feel are appropriate in the course of raising their children. Further, it is very difficult to determine the child's interest objectively. As the OLRC has noted, "[t]he social and psychological ramifications of disclosure are simply not clear; one cannot accurately predict the

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732. For the various positions held abroad, see appendix A, *infra* at 194ff.

733. A number of provisions to this effect are included in *An Act to amend the Uniform Child Status Act*, *supra*, note 199. These provisions make physicians responsible for keeping records, but access to records which may be related is made possible by a central registry. Responsibility for protecting the confidentiality of this information rests with the agency that receives it.

734. Identifying information has to be kept in any case because it is essential in terms of donor liability.

735. This may include information about the ethnic origin, profession, education, religious affiliation and interests of the parties involved. See, *e.g.*, Ministry of Community and Social Services, *Adoption Disclosure Services* (Toronto: The Ministry, 1987) at 5.

736. Lori B. Andrews, "Legal and Ethical Aspects of New Reproductive Technologies" (1986) 29:1 Clin. Obstet. Gynecol 190 at 198: "Some individuals who were conceived through artificial insemination and are now in their 20s and 30s feel that they have suffered emotionally as a result of being created with donor sperm. Like adoptees, some artificial insemination children feel that, for reasons of their psychological and medical well-being, they need to learn about or meet their biological fathers, the sperm donors." To the same effect, see Achilles, *supra*, note 709 at 110.

737. See *supra* at 60-61 and 90ff.

738. See *supra* at 60-61 and note 281.

implications in individual cases.''[739] Such decisions must take into account the personality and needs of the particular child and must be left to the discretion of the parents.[740]

On the other hand, the interest of the child is also at odds with the donor's interest in remaining anonymous. This therefore requires a balance to be struck between the donor's right to privacy and the child's right to know about his or her origins.

While identifying information has to be kept (as it is essential to establishing donor liability), it should be disclosed only if the donor consents when the child makes the request.[741]

At the request of the child or the parents, non-identifying social information should, however, be disclosed. Such general information is important to the child's psychological development and in no way infringes the donor's privacy.[742]

RECOMMENDATIONS

17. (1) Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties.

(2) Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care; to meet the psychological needs of the child; to ensure proper clinical reports; and to permit studies on the long-term effects of the various technologies used in medically assisted procreation.

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739. *Supra*, note 2 at 187.

740. Even in Sweden, where the child has the right to know about his or her origins, disclosure is left to the parents.

> The travaux préparatoires of the new legislation begin by affirming the importance of parental frankness and honesty towards the child. Parents ought therefore to tell the child about its origins at the earliest suitable opportunity. It has not been found appropriate to legislate on this point. Instead it is observed that, during the psychosocial counselling procedure which proceeds insemination, the physician should try to make the prospective parents understand the importance of being frank with the child.

Göran Ewerlöf, ''Artificial Insemination Legislation and Debate'' (1985) 29 Current Sweden 1 at 7.

741. It is interesting to note that in Sweden, while the enactment of a law that recognized the child's right to know about his or her origins initially led to a significant drop in the number of donors, it took only a few months for the situation to correct itself. Achilles, *supra*, note 709 at 105-15: ''[W]ithin months the number of donors had risen to previous levels, and reports indicate that a different kind of donor is becoming involved in programs.'' See also Bertil Wennergren, ''Consequences of New Regulations in Reproductive Medicine and Human Embryo Research in Their Relationship with Science, Ethics and Law. The Swedish Approach'' in Byk, ed., *supra*, note 640, 387 at 389; and Lena Jonsson, ''Artificial Insemination in Sweden'' in *Sortir la maternité du laboratoire*, *supra*, note 493, 148 at 154.

742. See *supra* at 90. Most recent reports on adoption and medically assisted procreation have recommended that non-identifying information be made available and that identifying information be disclosed only with the consent of the biological parents. See Knoppers and Sloss, *supra*, note 269 at 693-96.

(3) Clinics should be responsible for protecting the confidentiality of the information they hold.

18. The legal parents or the child should be able to request disclosure of non-identifying information, in particular social information (such as ethnic origin, profession, education, religious affiliation and interests of the donor). However, identifying information should be disclosed only with the donor's consent.

In light of the recent ruling in *R.* v. *Thornton*,[743] we can conclude that where a donor intentionally conceals important information or gives false information, such failure or negligence may be subject to prosecution under the *Criminal Code*, either section 180 (public mischief) or section 219 (criminal negligence).[744] It is therefore essential that donors' names be kept and that donors be prevented from using their right to remain anonymous in order to obtain immunity against criminal prosecution related to a false disclosure or a failure to disclose.[745]

RECOMMENDATION

19. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information for the purpose of a criminal prosecution related to such false disclosure or failure to disclose.

D. Long-term Evaluation

The uncertainty that prevails regarding the possible risks associated with medically assisted procreation means that vigilance is needed. For example, while the use of frozen gametes and embryos does not appear to pose a threat to safety at present, caution forces us to recommend that studies continue to monitor and examine the long-term effects of cryopreservation on health and safety. Generally, the long-term impact of the technologies on children born as a result of assisted procreation should also be monitored. And if studies on long-term effects are to be carried out, it is essential that records be properly kept and that data be compiled and made available nationally.[746]

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743. *Supra*, note 270.

744. See ss 180, 216 and 219 of the *Criminal Code*. Judge Flanigan in *R.* v. *Thornton* (*supra*, note 270) wrote at 34 of his decision: "Again it is my view that the Code has provided at least three sections that could cover the actions of the accused in this case. These include the sections dealing with criminal negligence, public mischief, and the sections relied upon by the Crown, that is, s. 180 and s. 216."

745. To the same effect, see the *Report on Human Sperm 1981*, *supra*, note 148 at 22. For more details, see appendix A, *infra* at 196.

746. Recs 9 and 17, *supra*, address these concerns.

RECOMMENDATION

20. Studies should be undertaken to determine and measure the long-term effects of medically assisted procreation technologies on the resulting children.

III. Implementing the Recommendations

A. Controlling Practice

Considering the inadequacy of the controls now in place,[747] and in order to effectively address the various aspects of public safety, we feel it is essential to regulate certain aspects of the activities of clinics and banks.[748] A system of certification could impose conditions and restrictions.[749] Obtaining certification would thus be conditional on clinics and banks meeting certain prerequisites (for example, the requirement to set up a counselling service and a filing system[750]), while compliance with other standards,[751] duties,[752] restrictions[753] or prohibitions[754] would be needed to maintain certification. This would make it possible to determine, for example, whether clinics and banks are observing the prohibitions on the selection and commercialization of gametes and embryos.[755] Finally, the system would also make it possible to regulate other aspects of medically assisted procreation, such as the forms used to record the intentions of those with control over gametes and embryos.[756]

RECOMMENDATION

21. (1) A system of certification for clinics and banks should be established in order to regulate the following issues:

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747. See *supra* at 101ff.

748. See "Regulation of Procedures," *supra* at 112. See also the recommendations on standards for the selection, screening and storage of gametes and embryos (rec. 10) and the recommendations that impose requirements (recs 9, 11 and 15 to 19), restrictions (recs 5(4), 6(4) and 12 to 14) or prohibitions (recs 2 and 3) on clinics and banks. The Commission recommended in *Biomedical Experimentation Involving Human Subjects* (*supra*, note 7) that standards governing the creation, expansion and management of sperm and embryo banks should be developed (*ibid.*, rec. 8(3) at 54).

749. Concerning the effects of certification, see, *inter alia*, *supra*, rec. 14.

750. See *supra*, recs 16 and 17.

751. Standards concerning, *e.g.*, selection, screening and storage of gametes and embryos; see *supra*, rec. 10.

752. See *supra*, recs 9, 11 and 15 to 19.

753. See *supra*, recs 5(4), 6(4) and 12 to 14.

754. See *supra*, recs 2 and 3.

755. See *supra*, recs 2 and 3.

756. See *supra*, recs 5 and 6.

(*a*) national standards for the selection, screening and storage of gametes and embryos;

(*b*) the requirement to submit annual reports to a central registry and the content of the reports;

(*c*) the requirement to freeze donated sperm and use it only after the donor has been properly tested for evidence of the AIDS virus;

(*d*) the duty to justify in writing the number of embryos implanted per treatment cycle;

(*e*) the duty to establish counselling services and the composition and duties of such counselling services;

(*f*) the duty to keep medical records and the content of those records;

(*g*) the duty to establish a system that allows the physician to link donors to recipients while protecting the anonymity of the parties;

(*h*) the duties pertaining to access to identifying and non-identifying information;

(*i*) the restrictions pertaining to the allowable use and time limits on the freezing of gametes and embryos, the frequency of use of gametes from the same donor and the import of gametes and embryos;

(*j*) the prohibitions pertaining to the selection and commercialization of gametes and embryos; and

(*k*) the conditions attached to the donation of gametes and embryos, the notion of control over gametes and embryos, the manner in which the person having such control may express his or her intentions and the terms and conditions governing the exercise of such intentions.

We must also ensure that private clinics do not circumvent proposed quality-control requirements by, for example, using fresh semen from their own network of donors, since such action could jeopardize the safety of the mother and the unborn child. Accordingly, it is important to restrict the practice of medically assisted procreation to certified clinics and to introduce sanctions for unauthorized operations.[757] In addition, it is important to

757. We are including artificial insemination here even though it is less invasive and more private in nature, because uncontrolled use of the technology could be harmful to the child. As stated earlier, it is essential that, for example, donors be carefully selected, that sperm undergo proper screening, and that identifying medical, genetic and social information be kept. Such controls would also ensure compliance with the restrictions on the selection of gametes and embryos: see *supra*, rec. 2. See also appendix A, *infra* at 197-98.

ensure that clinics and banks comply with the various prohibitions, restrictions and duties recommended in response to the various problems associated with the use of medically assisted procreation technologies (regarding, for example, the selection, commercialization and use of gametes and embryos).[758]

RECOMMENDATION

21. (2) The application of medically assisted procreation technologies should be restricted to certified clinics, and only certified banks should be permitted to store, preserve and import gametes and embryos.

B. The Need for a National Agency

How can all these recommendations be implemented? Whether they relate to principles, the administration of justice or public safety, the nature and purpose of the proposed recommendations are such that they require centralized, uniform control of medically assisted procreation. To such administrative control must be added the establishment of the certification system, regulatory activities, the monitoring of practices[759] and the establishment of a central registry. It is also essential, on the national level, to encourage the necessary research and studies and to undertake long-term studies.

The need for uniformity, whether in terms of social choices or control of practices or medically assisted procreation in general, and the need to avoid interprovincial "procreative tourism," mean that the federal, provincial and territorial governments must work together to establish national controls.[760]

It is certainly appropriate to co-ordinate and control the use of medically assisted procreation technologies, and it would be easy in a centralized country to create a statutory agency with the necessary powers and duties. In Canada, however, where the jurisdiction needed to exercise such control is shared by the federal government and the provinces, the two levels of government must work with the professionals involved to develop national controls.

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758. Similarly, see appendix A, *infra* at 197-98. This form of control would enhance the controls applied by professional associations that normally protect the public against malpractice or unlawful medical practice and provide ethical benchmarks.

759. This includes monitoring of compliance with regulatory duties, restrictions and prohibitions; see *supra* at 161.

760. Regarding the need for co-operation between the federal and provincial governments, see, *inter alia*, OLRC, *supra*, note 2, recs 9 and 17(2) at 276-77.

Creating a national agency with regulatory powers under both the federal and the provincial governments seems to be the best way of ensuring that our recommendations have the desired effect.[761]

We prefer this approach to the enactment of a general law on medically assisted procreation. Creating a national administrative agency would ensure the flexibility needed in this extremely complex field. Such an agency would provide for systematic intervention and proper control and would make it possible to solve problems that the law is currently unable to solve.

The agency should be a multidisciplinary team of qualified individuals. Its role would be to protect the public; grant certification; regulate certain aspects of the activities of banks and clinics and medically assisted procreation in general (certification criteria, terms and conditions of consent to donation and storage, and so on); ensure compliance with the various duties, standards, restrictions and prohibitions; establish a central registry; identify real problems on the basis of national data; analyse the various success rates and compile statistics; ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation; prevent exploitation and commercialization in the area of medically assisted procreation; promote any research and studies deemed necessary (research to determine the maximum freezing time for gametes and embryos, or aimed at reducing the number of multiple pregnancies or developing technologies that follow the natural cycle of ovulation, and so on); and advising the various governments on these matters. To fulfil this role, the agency would have to be empowered to inspect certified banks and clinics and, in cases of non-compliance with the applicable standards, duties, restrictions or prohibitions, amend, revoke or suspend their certification.

RECOMMENDATION

22. (1) The federal, provincial and territorial governments, in conjunction with the professionals involved, should explore the possibility of establishing a national regulatory agency in the area of medically assisted procreation.

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761. The Warnock Report (*supra*, note 421, para. 13.3 at 79) recommended establishment of the Statutory Licensing Authority, a regulatory agency independent of the government. Among other things, the Authority would control and regulate infertility services, gamete and embryo storage, research, licences and a central registry. The Interim Licensing Authority has assumed these duties pending the adoption of a statute establishing the Statutory Licensing Authority. In November 1990, the Human Fertilisation and Embryology Authority was created under the *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, s. 5. This agency should be fully operational in the summer of 1991 and should replace the Interim Licensing authority; see appendix A, *infra* at 199.

(2) The powers and duties of the national agency should be as follows:

(*a*) to grant certification;

(*b*) to set out in regulations the various standards, duties, restrictions and prohibitions referred to in recommendation 21(1) and to ensure compliance with those regulations;

(*c*) to establish a central registry;

(*d*) to identify problems on the basis of national data;

(*e*) to analyse the various success rates and compile statistics;

(*f*) to ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation;

(*g*) to prevent exploitation and commercialization in the area of medically assisted procreation;

(*h*) to promote any research and studies deemed necessary;

(*i*) to advise the various governments on these matters; and

(*j*) to inspect certified banks and clinics and, if need be, to amend, revoke or suspend their certification.

(3) The federal government should take the initiative of organizing meetings to discuss the establishment of such an agency.

Summary of Recommendations

1. Legislation governing access to medically assisted procreation technologies should respect the right to equality. Access should be limited only in terms of the cost and scarcity of resources. Where limitation is necessary, selection should not be based on unlawful grounds for discrimination within the meaning of federal and provincial legislation (family status, marital status, sexual orientation, and so on).

2. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited, except where the objective is to prevent the transmission of serious genetic diseases.

3. (1) All commercialization of the donation of gametes and embryos should be prohibited. Only reimbursement of reasonable expenses incurred by donors should be permitted.

(2) Gamete and embryo banks should not be permitted to operate on a profit basis. However, banks should be allowed to be reimbursed for reasonable costs related to their operations.

4. Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence.

5. (1) Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control, abandonment of the parental project, expiry of the time limit on freezing, or a divorce or other dispute between the persons with control. A person with control should be able to change, in writing, his or her stated intentions regarding the fate of the embryos as long as the embryos have not been used for their intended purpose; in cases where control over the embryos is shared by two people, both must agree to any changes.

(2) Control over embryos conceived using gametes from a couple should be exercised jointly by the partners. Control over embryos conceived using gametes from only one of the partners and a donor should vest in the partner genetically linked to the embryos. Control over embryos conceived with donated gametes should vest in the bank or clinic that has the embryos in its possession.

(3) The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing.

(4) The person with control over an embryo who decides to donate the embryo should be required, before the donation is made, to make a written statement expressing his or her consent to the donation, and stating the conditions attached to the donation respecting the utilization of the embryo. That person should also be able to change those conditions or withdraw consent by making a written statement to that effect at any time before the donated embryo is used; in cases where control over the embryo is shared by two partners, both must agree to any change.

6. (1) Control over gametes should vest in the producer.

(2) A person depositing his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes in such circumstances as the death of the person with control, abandonment of the parental project or expiry of the time limit on freezing. The depositor should be able to change, in writing, his or her stated intentions regarding the fate of the gametes before any embryos are created or the gametes are used for their intended purpose.

(3) A person who donates his or her gametes should be required, before the donation is made, to make a written statement expressing his or her consent to the donation and stating the conditions attached to his or her donation respecting the use of the gametes. The donor should be able to change these conditions or withdraw his or her consent by making a written statement to that effect at any time before embryos are created or the donated gametes are used.

(4) Possible uses of gametes should be limited to fertilization, experimentation and destruction; fertilization should be prohibited beyond the time limit on freezing.

7. (1) Provincial parentage laws should reflect the intentions of couples who use medically assisted procreation; accordingly, actions to disavow paternity by a father who gave his consent or to challenge paternity by a third party on the grounds that a donation from a third person was used should not be allowed.

(2) It should not be possible to establish a bond of parentage between a donor and the child.

(3) Legislation that still makes a distinction between legitimate and illegitimate children should recognize children born as a result of medically assisted procreation as having the status of legitimate children.

8. Provincial succession laws should be harmonized to establish that children born as a result of the post-mortem use of gametes or embryos may not inherit unless there is a specific reference to that effect in the will of the deceased producer.

9. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry; the minimum content of the reports should be set and the data should be presented in a prescribed form.

10. Uniform and mandatory standards for the selection, screening and storage of gametes and embryos, and the selection and screening of donors, should be developed at the national level.

11. Donated sperm should be frozen and should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus.

12. (1) Embryos should not be frozen for more than five years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this five-year limit.

(2) Gametes should not be frozen for more than ten years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this ten-year limit.

13. A limit should be placed on the number of times gametes from the same donor may be used. Further, the studies needed to set an appropriate limit should be encouraged.

14. The import of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should have to meet Canadian standards.

15. Every effort should be made to reduce the risk of multiple pregnancy and to promote the development of technologies that follow the normal cycle of ovulation. Accordingly, the federal government should encourage studies and research aimed at reducing the multiple-pregnancy rate and developing technologies that follow the normal cycle of ovulation. Further, clinics should be required to document and justify the number of embryos implanted in each treatment cycle.

16. Every clinic offering medically assisted procreation services should be required to provide to persons using medically assisted procreation, either before, during or after the application of a technology, counselling services whereby these persons could obtain from experts (psychologists, physicians and so on) the assistance and information they might need concerning the specific problems involved in medically assisted procreation.

17. (1) Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties.

(2) Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care; to meet the psychological needs of the child; to ensure proper clinical reports; and to permit studies on the long-term effects of the various technologies used in medically assisted procreation.

(3) Clinics should be responsible for protecting the confidentiality of the information they hold.

18. The legal parents or the child should be able to request disclosure of non-identifying information, in particular social information (such as ethnic origin, profession, education, religious affiliation and interests of the donor). However, identifying information should be disclosed only with the donor's consent.

19. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information for the purpose of a criminal prosecution related to such false disclosure or failure to disclose.

20. Studies should be undertaken to determine and measure the long-term effects of medically assisted procreation technologies on the resulting children.

21. (1) A system of certification for clinics and banks should be established in order to regulate the following issues:

(*a*) national standards for the selection, screening and storage of gametes and embryos;

(*b*) the requirement to submit annual reports to a central registry and the content of the reports;

(*c*) the requirement to freeze donated sperm and use it only after the donor has been properly tested for evidence of the AIDS virus;

(*d*) the duty to justify in writing the number of embryos implanted per treatment cycle;

(*e*) the duty to establish counselling services and the composition and duties of such counselling services;

(*f*) the duty to keep medical records and the content of those records;

(*g*) the duty to establish a system that allows the physician to link donors to recipients while protecting the anonymity of the parties;

(*h*) the duties pertaining to access to identifying and non-identifying information;

(*i*) the restrictions pertaining to the allowable use and time limits on the freezing of gametes and embryos, the frequency of use of gametes from the same donor and the import of gametes and embryos;

(*j*) the prohibitions pertaining to the selection and commercialization of gametes and embryos; and

(*k*) the conditions attached to the donation of gametes and embryos, the notion of control over gametes and embryos, the manner in which the person having such control may express his or her intentions and the terms and conditions governing the exercise of such intentions.

(2) The application of medically assisted procreation technologies should be restricted to certified clinics, and only certified banks should be permitted to store, preserve and import gametes and embryos.

22. (1) The federal, provincial and territorial governments, in conjunction with the professionals involved, should explore the possibility of establishing a national regulatory agency in the area of medically assisted procreation.

(2) The powers and duties of the national agency should be as follows:

(*a*) to grant certification;

(*b*) to set out in regulations the various standards, duties, restrictions and prohibitions referred to in recommendation 21(1) and to ensure compliance with those regulations;

(*c*) to establish a central registry;

(*d*) to identify problems on the basis of national data;

(*e*) to analyse the various success rates and compile statistics;

(*f*) to ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation;

(*g*) to prevent exploitation and commercialization in the area of medically assisted procreation;

(*h*) to promote any research and studies deemed necessary;

(*i*) to advise the various governments on these matters; and

(*j*) to inspect certified banks and clinics and, if need be, to amend, revoke or suspend their certification.

(3) The federal government should take the initiative of organizing meetings to discuss the establishment of such an agency.

APPENDIX A

Comparative Study of Foreign and Canadian Texts Dealing with Medically Assisted Procreation

Introduction[1]

Medically assisted procreation has been the focus of numerous studies and reports in recent years. These studies and reports have led some countries to adopt new legislation. Before analysing the measures that have been recommended or adopted, we should briefly explain the initiatives taken in this area in countries other than Canada, as well as in Canada and in Quebec.[2]

In Australia, the state of Victoria was the first to pass general legislation regulating medically assisted procreation and surrogate motherhood.[3] The Commonwealth of Australia and other states have also enacted legislation,[4] and all Australian states have produced reports on medically assisted procreation.[5] Finally, the Family Law Council has issued recommendations on surrogacy contracts,[6] and the National Bioethics Consultative Committee has investigated the problems associated with access to information and with surrogacy.[7]

In Denmark, the Danish Council of Ethics broached the issue of medically assisted procreation in 1990.[8] In 1988, Spain passed a law on all medically assisted procreation

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1. The reader will find at the end of this appendix a list of the texts referred to, listed and numbered according to country, *infra* at 214-20.

2. For an overview of the state of the law around the world, see Jan Stepan, ed., *International Survey of Laws on Assisted Procreation* (Zurich: Schulthess Polygraphischer, 1990). See also EASTERN EUROPE 1.

3. VICTORIA 1. See also VICTORIA 2.

4. COMMONWEALTH OF AUSTRALIA 1; SOUTH AUSTRALIA 1 and SOUTH AUSTRALIA 2; WESTERN AUSTRALIA 1; NEW SOUTH WALES 1 and NEW SOUTH WALES 2; QUEENSLAND 1 and QUEENSLAND 2; TASMANIA 1; NORTHERN TERRITORY 1.

5. SOUTH AUSTRALIA 3; WESTERN AUSTRALIA 2; NEW SOUTH WALES 3, NEW SOUTH WALES 4 and NEW SOUTH WALES 5; QUEENSLAND 3; VICTORIA 3 and VICTORIA 4.

6. AUSTRALIA 1.

7. COMMONWEALTH OF AUSTRALIA 2 and COMMONWEALTH OF AUSTRALIA 3. In October 1990, the National Bioethics Consultative Committee released two discussion papers; see COMMONWEALTH OF AUSTRALIA 4 and COMMONWEALTH OF AUSTRALIA 5.

8. DENMARK 1; the report includes recommendations aimed at protecting human substances, and draft regulations on artificial insemination.

technologies, based on the work of the Council of Europe.[9] In 1989, the Council of Europe authorized the release of the report of its ad hoc Committee of Experts on Progress of Biomedical Sciences (CAHBI) in the hope that it would help harmonize the regulation of medically assisted procreation by member states.[10]

In the United States, some 30 states have passed legislation on the parentage of children born as a result of artificial insemination by donor (AID).[11] Louisiana and Pennsylvania have passed laws to regulate the clinical use of in vitro fertilization (IVF), and Ohio has done likewise for AID.[12] The increasingly frequent use of surrogacy has led to a number of statutes being passed[13] and to a large number of bills being introduced.[14] The New York Task Force on Life and the Law published recommendations and draft legislation on surrogacy in 1988,[15] and the American Fertility Society and its ethics committee have issued recommendations and guidelines on medically assisted procreation technologies.[16]

France has not passed any legislation on these matters, with the exception of *Décret n° 88-327*, which approaches medically assisted procreation from the perspective of professional control and hospital organization.[17] However, France's Conseil d'État released a report in 1988 dealing specifically with medically assisted procreation,[18] and a draft bill giving effect to the recommendations in the report has since been tabled in the French National Assembly.[19]

In 1987, the Norwegian parliament passed a law regulating artificial insemination and in vitro fertilization[20] on the basis of recommendations made in a legislative proposal.[21]

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9. See SPAIN 1. See also SPAIN 2 and SPAIN 3 at 241.

10. COUNCIL OF EUROPE 1. However, the committee did not give the report official recommendation status.

11. See, *e.g.*, LOUISIANA 1; MISSOURI 1, s. 210.824; NEW YORK 1, s. 1. See also UNITED STATES 5.

12. LOUISIANA 2, ss 121 to 133; PENNSYLVANIA 1, s. 3213; OHIO 1, ss 3111.30 to 3111.38. See also UNITED STATES 4 at 249; LOUISIANA 4, s. 1062.1, and DELAWARE 1, s. 2801, regarding tests to screen gamete donations; ILLINOIS 1, para. 6(7), regarding the sale of and experimentation on fetuses; TEXAS 1, s. 3A, regarding insurance coverage of services.

13. See, *e.g.*, ARKANSAS 1, s. 9-10-201; INDIANA 1, ss 31.8.1.2 to 31.8.2.1; KENTUCKY 1; LOUISIANA 3; MICHIGAN 1, ss 722.853 to 722.861; NEBRASKA 1; NEVADA 1, ss 127.287 and 127.288. See also UNITED STATES 3.

14. See NEW YORK 2 at 99 n. 13. See also draft legislation in the following states: Alabama, Arizona, Connecticut, Delaware, Florida, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Wisconsin.

15. See the *Proposed Surrogate Parenting Act*, NEW YORK 2 at A-1.

16. Only the most recent recommendations are cited; see UNITED STATES 1 and UNITED STATES 2.

17. FRANCE 1.

18. FRANCE 6.

19. See FRANCE 5. The proposed legislation amends the *Code de la santé publique* (FRANCE 2), the *Code civil* (FRANCE 3) and the *Code pénal* (FRANCE 4). The affected provisions are cited following each section of the preliminary draft legislation.

20. NORWAY 1.

21. NORWAY 2.

In the United Kingdom, the *Surrogacy Arrangements Act 1985*[22] deals with surrogate motherhood, while the *Human Fertilisation and Embryology Act 1990*[23] covers all the technologies used in medically assisted procreation. The latter statute followed the recommendations of the first significant study in this area, carried out under the direction of Dame Mary Warnock,[24] which produced a legislative proposal, the White Paper.[25] Further, annual reports are prepared by the Interim Licensing Authority,[26] an agency established as a result of the Warnock report that operates without enforcing authority.

The Riksdag in Sweden passed legislation on artificial insemination in 1984[27] and IVF in 1988.[28] In December 1990 the parliament of the former Federal Republic of Germany passed a law aimed primarily at protecting embryos and preventing "misuse" of medically assisted procreation.[29]

In Canada, the first published studies dealt only with artificial insemination. The report of British Columbia's Royal Commission on Family and Children's Law was released in 1975,[30] while the report of the Advisory Committee on the Storage and Utilization of Human Sperm was submitted to the Minister of National Health and Welfare in 1981.[31]

The issue of medically assisted procreation was first addressed as a whole in a 1985 report by the Ontario Law Reform Commission. The underlying principle was that the state should not intervene in matters of procreation, but the report concluded that legislative intervention was needed because of the implications of medically assisted procreation for people other than the prospective parents.[32]

In March 1987, the Law Reform Commission of Saskatchewan released a short report and a proposal for legislation on artificial insemination that focused primarily on the legal status of the child and the donor.[33]

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22. United Kingdom 1.
23. United Kingdom 2.
24. United Kingdom 5.
25. United Kingdom 6.
26. United Kingdom 4. See also United Kingdom 3.
27. Sweden 1. Regulations have also been adopted, see Sweden 3.
28. Sweden 2. See also Sweden 4 and Sweden 5 at 387.
29. See Germany 1.
30. British Columbia 1.
31. Canada 3.
32. Ontario 1 at 119-20.
33. Saskatchewan 1.

In June 1989, the British Columbia Branch of the Canadian Bar Association released a report on medically assisted procreation; the main elements of the report were adopted as basic CBA policy in March 1990.[34]

In its February 1990 report, the Canadian Advisory Council on the Status of Women took a different approach to medically assisted procreation, giving primary consideration to the prevention of infertility.[35]

Finally, the Canadian Fertility and Andrology Society issued guidelines on artificial insemination by donor in 1988[36] and recently co-published with the Society of Obstetricians and Gynaecologists of Canada an analysis of all medically assisted procreation technologies.[37]

In Quebec, the ad hoc committee of the Barreau du Québec issued its recommendations on medically assisted procreation in April 1988.[38] In 1988[39] and April 1989,[40] the Department of Health and Social Services released reports dealing respectively with the incorporation of the technologies in the Quebec health-care system and the approach to be taken in this area. And finally, the Conseil du statut de la femme has since 1985 been focusing special attention on medically assisted procreation. Seven reports and various communiqués collected during an international forum organized by the Council were used to prepare an overview of the issues[41] that was submitted to the Quebec government in May 1989. In December 1990, the Minister of Justice of Quebec tabled Bill 125, *Civil Code of Québec*, five articles of which deal specifically with medically assisted procreation.[42]

Many important initiatives have been taken in an effort to understand the implications of medically assisted procreation. The substance of the measures that have been taken or recommended is analysed in three main sections: general principles; safety of medically assisted procreation technologies; and medical control and regulation.

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34. Canada 2.

35. Canada 1. The report treats medically assisted procreation as experimentation.

36. Canada 4.

37. Canada 5.

38. Quebec 1.

39. Quebec 5. In a dissenting opinion in the 1988 report, Francine McKenzie criticized the liberalism that characterizes the determination of infertility (one year of sexual intercourse without contraception) and the selection of candidates (candidates may already have had children or been voluntarily sterilized). She condemned the relentless procreative activity to which women may fall victim, the trivialization of the serious social risks inherent in assisted reproduction technologies, and the triumph of technology over human concerns, and expressed her opposition to the expansion of and additional funding for fertility clinics in Quebec. See *Opinion synthèse de Madame McKenzie*, issued in a press release from the Conseil du statut de la femme, 18 April 1988.

40. Quebec 6.

41. Quebec 4; see also Quebec 3.

42. Quebec 7, arts 579 to 583.

I. General Principles

Some aspects of medically assisted procreation involve choices with respect to principles and values. These aspects include access, commercialization, surrogacy, control over gametes and embryos, and parentage.

A. Access

Access to medically assisted procreation is a major issue addressed in most of the legislation and reports that deal with the matter. Restrictions are common, and France's Conseil d'État goes so far as to recommend criminal sanctions against physicians who violate them.[43] However, some countries suggest that no criteria be imposed and that the decision on access be left to the physician.[44] Where criteria are used, there are two types: personal and medical.

1. Personal Criteria

The personal criteria most often considered in determining access include marital status, sexual orientation, stability and spousal consent.

The marital status of those who wish to use the technologies is not a restrictive criterion. Except in Norway,[45] the laws and reports do not require that couples be actually married.

The sexual orientation of the couple and whether or not the prospective parents are a couple are criteria that severely restrict access. A number of countries recommend that only heterosexual couples be accepted.[46] However, the Ontario Law Reform Commission report allows single women access,[47] and the reports of the Quebec Department of Health and Social Services[48] and the American Fertility Society[49] would give women access to artificial insemination regardless of their status. Spanish statutes,[50] the Canadian

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43. France 5, s. 10 — France 2, L. 675. See also New South Wales 1, s. 9, New South Wales 3, para. 6.14, rec. 8, and New South Wales 4, rec. 9 at 66-67, which provide that physicians who fail to consider certain factors in their choice of treatment are deemed to have engaged in "professional misconduct."

44. United Kingdom 5, rec. 24 at 82, and United Kingdom 6, para. 78; Canada 1 at 26-27, and Canada 2 at 22.

45. Norway 1, s. 4. It should be noted that the draft legislation gave access to unmarried couples.

46. See, *e.g.*, South Australia 2, ss 13(3), 13(4) and 13(7); Victoria 1, ss 10 to 13A; this policy would not apply to AI. Council of Europe 1, guideline 1; France 5, s. 10 and pp. 27-28 — France 2, L. 668-10 and L. 675; Norway 1, s. 4; Sweden 1, s. 2, Sweden 2, s. 2, and Sweden 5 at 388; Quebec 1 at 36-37, rec. 3, Quebec 4 at 13, recs 2.1 and 3.1, and Quebec 5, rec. 38 (for IVF). See also, table 1, *infra* at 201-202.

47. Ontario 1, rec. 5.

48. Quebec 5, rec. 11, allowing [Translation] "single women, whatever their status."

49. United States 1, guideline IV.

50. Spain 1, s. 6, Spain 2 at 237, and Spain 3 at 242.

Fertility and Andrology Society[51] and the Danish Council of Ethics[52] all accept single women or women who are part of a homosexual couple. Finally, some countries do not exclude single women.[53]

The stability of the couple[54] and the spouse's consent to the procedure[55] are sometimes required.

2. Medical Criteria

The medical criteria most commonly used in determining access include medical and social assessment, infertility and the transmission of genetic disorders.

A medical assessment, possibly including psychological and social evaluation, is sometimes mandatory,[56] and evaluation of the welfare of the unborn child is recommended in some instances.[57]

It is often stated that those who wish to obtain access to artificial procreation technologies must be infertile, sterile or likely to transmit a genetic disease.[58] For

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51. CANADA 4 at 10; CANADA 5 at 28, rec. 11: "[D]ecision to restrict access to treatment should not be based on discriminating or stereotypical judgments."

52. DENMARK 1 at 95, rec. 5.1 at 124 and reg. 2.1 at 131.

53. UNITED STATES 2 at 24S; UNITED KINGDOM 2, ss 13(6); BRITISH COLUMBIA 1, recs 3, 4, 5 and 14 : favours adoption access criteria. NEW SOUTH WALES 1, ss 3(1), 7(2)d and 9, NEW SOUTH WALES 3 at 43-44, para. 6.14 and rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (however, the following factors must be considered: whether the woman is part of a couple; the infertility of the couple or the risk of transmission of a genetic disorder; the welfare and interest of the child; the stability of the family; the need for counselling; age and physical and mental health of the prospective parent(s)).

54. See, *e.g.*, NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 (stability considered but not necessarily conclusive); ONTARIO 1, rec. 5, and CANADA 4 at 10; QUEBEC 1 at 36. See also, table 2, *infra* at 203-205. *Contra*: CANADA 1 at 26-27.

55. VICTORIA 1, ss 10 to 13A (this requirement does not apply in the case of AI) and QUEENSLAND 3, rec. B(2) (vii); DENMARK 1, reg. 1.1 at 131; SPAIN 1, s. 6, SPAIN 2 at 237, and SPAIN 3 at 242; OHIO 1, ss 3111.34 and 3111.35, and UNITED STATES 1, guideline IV; FRANCE 5, s. 10 and p. 28; FRANCE 2, L. 668-11 and L. 675; NORWAY 1, s. 4; UNITED KINGDOM 5, recs 21, 22 and 27 at 82-83; SWEDEN 1, s. 2, SWEDEN 2, s. 2, SWEDEN 3 and SWEDEN 5 at 388-89; BRITISH COLUMBIA 1, rec. 1, and CANADA 3 at 27 and rec. 3.4. *Contra:* NEW SOUTH WALES 3, rec. 10, and NEW SOUTH WALES 4, rec. 8 at 65-66; CANADA 2 at 15.

56. VICTORIA 1, s. 18; NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (the medical assessment is considered but not mandatory); SPAIN 1, ss 2 and 6; NORWAY 1, s. 5; SWEDEN 1, s. 3; BRITISH COLUMBIA 1, recs 3, 4, 5 and 14. *Contra*: QUEBEC 5, rec. 39 (the requirements cannot be stricter than for natural procreation).

57. NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65; VICTORIA 1 (see s. 1(9), schedule 3, of the *Infertility (Medical Procedures) Regulations 1988)*; COUNCIL OF EUROPE 1, guideline 1; UNITED KINGDOM 2, para. 13(5); SWEDEN 1, s. 3.

58. SOUTH AUSTRALIA 2, paras 13(3) and 13(7); NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (couples only, must be considered but is not mandatory); QUEENSLAND 3, recs B(2) (i) and B(2) (ii); VICTORIA 1, ss 10 to 13A (except for AI); COUNCIL OF EUROPE 1,

example, several states in Australia require one to two years of alternative treatment,[59] and the report by the Quebec Conseil du statut de la femme recommends increasing from one year to two years the period of unprotected intercourse without conception needed to prove infertility.[60] With respect to the transmission of genetic disorders, France's Conseil d'État requires a high probability of transmitting an incurable disorder,[61] the Council of Europe a serious genetic disorder or disease which, in the opinion of the attending physician, would result in early death or severe disability.[62]

Finally, choosing the sex of the child is not normally permitted unless there is a risk of transmitting a serious sex-linked hereditary disease,[63] and "minimal" matching of the donor's features with those of the spouse of the inseminated woman is generally advised.[64]

B. Commercialization

The laws and recommendations of many countries prohibit the commercialization of medically assisted procreation. The prohibition may be stated in general terms, or specific reference may be made to the gratuity of donations or to prohibition of the sale of gametes and embryos.[65] Compensation is therefore limited to reimbursement of the reasonable expenses incurred by donors (traveling expenses, medical expenses, lost income).[66]

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guideline 1; FRANCE 5, s. 10 and pp. 26-27; FRANCE 2, L. 668-10 and L. 675-1; NORWAY 1, ss 8 to 12; ONTARIO 1, rec. 1 (except for single women); QUEBEC 1 at 36 and rec. 3, QUEBEC 4 at 13 and rec. 2.1, and QUEBEC 5, recs 11 and 38 (for AID). It should be noted that some jurisdictions accept the techniques as treatments for infertility but in their recommendations on access do not require infertility. See, *e.g.*, UNITED KINGDOM 5, recs 4 to 7 and 28 at 80 and 83.

59. VICTORIA 1, ss 10 to 13A, VICTORIA 4, para. 3.6 and QUEENSLAND 3, rec. B(2) (ii).

60. QUEBEC 4 at 10 and recs 1.5, 2.1 and 3.1. See also QUEBEC 5, rec. 2, which suggests reviewing the one-year period.

61. FRANCE 5, s. 10 — FRANCE 2, L. 668-10.

62. COUNCIL OF EUROPE 1, guideline 1.

63. UNITED STATES 2 at 20S; UNITED KINGDOM 5, paras 9.11, 9.12 and rec. 29 at 83; COUNCIL OF EUROPE 1, guideline 1; GERMANY 1, s. 3; CANADA 5 at 46-47, rec. 28. QUEBEC 4 at 13 and rec. 2.6, QUEBEC 5, rec. 12. *Contra*: ONTARIO 1, rec. 28.

64. UNITED KINGDOM 5, para. 4.21; COUNCIL OF EUROPE 1 at 19-20; UNITED STATES 1, guideline VIII and OHIO 1, s. 3111.35; CANADA 4 at 6-7; CANADA 5 at 30, rec. 13; QUEBEC 5, rec. 16.

65. NEW SOUTH WALES 1, s. 12; VICTORIA 1, ss 11 to 13A; DENMARK 1, rec. 11.1 at 127; SPAIN 1, ss 5 and 20; COUNCIL OF EUROPE 1 at 25 and guidelines 9(1) and 9(2); ILLINOIS 1, para. 6(7); LOUISIANA 2, s. 122; FRANCE 5, s. 10 — FRANCE 2, L. 668-6 and L. 668-13; UNITED KINGDOM 2, s. 12 and para. 41(8), and UNITED KINGDOM 4, guideline 15d); SWEDEN 1, s. 7, and SWEDEN 2, s. 4; CANADA 1 at 28; QUEBEC 1 at 23, and recs 3 and 7, QUEBEC 4 at 13, rec. 2.4, QUEBEC 5, recs 20, 51 and 53, QUEBEC 6 at 61, and QUEBEC 7, art. 25.

66. NEW SOUTH WALES 1, s. 12, and NEW SOUTH WALES 3, para. 10.9, rec. 24; QUEENSLAND 3, rec. C(5)(vi); VICTORIA 1, ss 11 to 13A, and appendix 4, s. 3; COUNCIL OF EUROPE 1, guideline 9(1); UNITED STATES 1, guideline VII(C), and UNITED STATES 2 at 45S, 49S and 52S; FRANCE 5, s. 10 FRANCE 2, L. 668-6 (lost income is not covered); UNITED KINGDOM 5, para. 4.27, rec. 26 at 82, and UNITED KINGDOM 6, para. 63; BRITISH COLUMBIA 1 at 23; ONTARIO 1, rec. 15; CANADA 3 at 27, CANADA 4 at 9, and CANADA 5 at 41, rec. 25; QUEBEC 1 at 23, and QUEBEC 5, rec. 21.

Where they are mentioned, gamete and embryo banks that operate for profit are generally prohibited.[67] However, the Ontario report would allow duly licensed and regulated gamete banks to operate on a commercial basis, subject to government control. A fee comprising expenses and perhaps a reasonable profit would be established, but sales would be restricted to physicians, hospitals and other licensed banks.[68]

C. Surrogacy

The countries that have taken a position on surrogacy have chosen to ban, discourage or, in very rare cases, regulate the practice.

A complete prohibition of all forms of surrogacy is relatively rare.[69] Instead, countries try to discourage surrogate motherhood and to tackle the commercial aspect of the practice. Thus, they prohibit even non-commercial activity by agencies or other intermediaries;[70] the use of any advertising related to surrogate motherhood;[71] and paying or accepting any financial or other compensation in connection with a surrogacy contract.[72]

Other countries do not prohibit surrogacy, permit gratuitous contracts, or have refrained from passing legislation to counter private agreements. Accordingly, intermediaries working

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67. See, *e.g.*, COUNCIL OF EUROPE 1 at 25 and guideline 9(2) (costs of collection, retrieval, storage, implantation and medical services may be reimbursed); FRANCE 5, s. 10 — FRANCE 2, L. 668-13; QUEBEC 5, rec. 53, and QUEBEC 6 at 61. See also the general prohibitions in the preceding notes.

68. ONTARIO 1, recs 17 and 18: the suggested approach is similar to that used by the Canadian Red Cross Society. See also CANADA 5 at 39, rec. 23, which recommends that, in the absence of adequate public funding, commercial banks be established.

69. GERMANY 1, s. 1(1)7; FRANCE 5, s. 16 — FRANCE 4, s. 353.1; QUEENSLAND 2, ss 2 and 3; QUEBEC 1 at 27-30 and rec. 17. See also DENMARK 1 at 100, which opposes surrogate motherhood but does not propose changes to criminal legislation on the matter. With respect to U.S. law, see UNITED STATES 3.

70. SOUTH AUSTRALIA 1, s. 10h; NEW SOUTH WALES 5, recs 5 and 6 at 44-53; VICTORIA 1, s. 30; AUSTRALIA 1, rec. 17 and para. 6.6.16; COUNCIL OF EUROPE 1, guidelines 15(1), 15(3) and 15(4); MICHIGAN 1, s. 722.859, section 9; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act*; FRANCE 5, s. 16 and pp. 31-32 — FRANCE 4, s. 353.1; UNITED KINGDOM 1, s. 2, UNITED KINGDOM 5, para. 8.18 and rec. 58 at 86, and UNITED KINGDOM 6, para. 73; QUEBEC 1, recs 18 and 20, QUEBEC 4 at 21 and rec. 4.1, QUEBEC 5, recs 56 and 57, and QUEBEC 6 at 60.

71. See, *e.g.*, SOUTH AUSTRALIA 1, s. 10h; NEW SOUTH WALES 5, rec. 4 at 43-44; QUEENSLAND 2, s. 3; VICTORIA 1, s. 30; AUSTRALIA 1, para. 6.6.16; COUNCIL OF EUROPE 1, guideline 15(3); UNITED KINGDOM 1, para. 3(1); QUEBEC 4 at 21 and rec. 4.2, QUEBEC 5, rec. 56, and QUEBEC 6 at 60.

72. SOUTH AUSTRALIA 1, ss 10g and 10h (for intermediaries); NEW SOUTH WALES 5, rec. 3 and pp. 40-43; QUEENSLAND 2, s. 3; VICTORIA 1, s. 30; AUSTRALIA 1, rec. 17 and para. 6.6.15; COUNCIL OF EUROPE 1, guideline 15(4); MICHIGAN 1, s. 722.859, section 9, and NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (except costs permitted in adoption, medical and legal costs, excludes lost wages); UNITED KINGDOM 1, s. 2(3) (except payment to the surrogate mother); CANADA 1 at 28, and CANADA 2, pp. 26-33, and rec. 9(d). *Contra*: NEVADA 1, s. 127.287. See also UNITED STATES 3.

free of charge or on a not-for-profit basis are not prohibited.[73] Reimbursement limited to expenses is possible.[74] In certain cases the parties themselves cannot be prosecuted.[75] Finally, the most frequently recommended measure is to make surrogacy contracts unenforceable in a court of law or declare them null and void.[76]

The American Fertility Society allows surrogate motherhood for strictly medical reasons and views it as a clinical experiment that has to be studied in detail. The parties would be informed of the psychological risks surrogacy may entail.[77]

The report of the Ontario Law Reform Commission recommends the legalization of regulated agreements. A major role is assigned to the courts, which would have to approve agreements before conception but after evaluating the parenting abilities of the future parents, their stability as individuals and as a couple, and the medical reasons for using the procedure. The judge would also have to consider the prospective surrogate: physical and mental health, marital situation and partner's opinion, and the impact on any other children. He or she would have to ensure that blood tests are performed in order to prevent

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73. South Australia 1, s. 10h; Victoria 1, s. 30; Michigan 1, s. 722.859; New York 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (the physician may be paid for his or her services); United States 2 at 67S; United Kingdom 1, s. 2.

74. Michigan 1, s. 722.853, section 3a; New York 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (excludes lost wages); United States 2 at 67S (accepts the possibility of higher payment); United Kingdom 1, para. 2(3) (excludes payment received by surrogate mother); Ontario 1 at 253-55, rec. 51; Canada 5 at 42, rec. 26.

75. United Kingdom 5, para. 8.19, and United Kingdom 6, para. 73; Quebec 5, rec. 57; Germany 1, s. 1: [Translation] "Anyone will be punished with up to three years imprisonment, or a fine, who: ... (vii) attempts to perform artificial insemination or embryo transfer on a woman prepared to permanently give up her child after birth (surrogate mother)." However, subsection (3) excludes the surrogate mother and the social parents from the application of the Act: [Translation] "(3) ... in the case of section I(vii), the surrogate mother and the person who wishes to take long-term care of the child will not be punished." However, in other countries, parties may be prosecuted where there is payment or advertising; see *infra*, table 4 at 210-13.

76. South Australia 1, s. 10g; New South Wales 5, rec .8 at 55-60; Queensland 2, s. 4; Victoria 1, para. 30(3); Australia 1, rec. 17 and para. 6.6.15; Commonwealth of Australia 3 at 36; Spain 1, s. 10, Spain 2 at 237 and Spain 3 at 242; Council of Europe 1, guideline 15(2); Indiana 1, s. 31.8.2.1; Michigan 1, s. 722.855, section 5; New York 2, s. 2 of the *Proposed Surrogate Parenting Act*; France 5, s. 11 — France 3, s. 342-12; United Kingdom 2, para. 36(1) (which amends the *Surrogacy Arrangements Act 1985*), United Kingdom 5, para. 8.19, rec. 59 at 86, and United Kingdom 6, para. 73; Canada 2, rec. 9(b) (the surrogacy contract would be valid but not binding on the surrogate); Quebec 1, rec. 18, and Quebec 7, art. 582. See also United States 3.

77. United States 2 at 67S. Similarly, see Canada 5 at 27, rec. 10:

> The Societies recommend:
> 1. that surrogacy be permitted for medical reasons; and
> 2. that ongoing research be conducted to carefully evaluate the impact of surrogacy on all parties involved.

See also Council of Europe 1, guidelines 11 and 15(4) (the Council leaves member states free to decide whether or not to prohibit).

any subsequent challenge respecting the child's parentage, approve any possible payment and ensure that the parties agree on the following matters: insurance, death or separation of the applicants, behaviour and diet before and during the pregnancy, diagnostic examinations, terms and conditions for transferring the child, and future relations between the surrogate and the child.[78]

D. Control over Gametes and Embryos

Recommendations on control over gametes and embryos often differ considerably from country to country. For example, some countries hold the view that donors have a property right over their gametes,[79] while others feel that the legal system applicable to embryos is that of persons.[80] Louisiana even grants legal existence to in vitro embryos until they are implanted.[81] The extent to which the various parties may control gametes and embryos is examined from two different perspectives: the exercise of control and post mortem fertilization.

1. The Exercise of Control

Generally, control of human products is exercised through a consent form which indicates how gametes and embryos may be used.

(a) Consent

Consent to the donation and storage of gametes and embryos must in most cases be written and sometimes requires the signatures of both partners.[82] Some countries require that the consent form signed at the time of the donation include the conditions under which

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78. Ontario 1, recs 34 to 66; hearings must be held *in camera*, and agencies would be regulated. It should also be noted that one Commissioner objected to the legalization of surrogacy itself: *ibid.* at 287-91. Commonwealth of Australia 3 at 36: it is recommended that surrogacy not be prohibited altogether, but that its application be strictly controlled.

79. New South Wales 3, para. 10.14, and New South Wales 4, rec. 23i) at 86. See, however, United Kingdom 5, paras 10.11 and 11.17, recs 42 and 62 at 84 and 86, where it is proposed that the embryo be afforded legal protection, without there being property rights over human embryos, and Canada 2, rec. 10(d) (human tissue not to be treated as a commodity).

80. Quebec 1 at 15; France 5 at 34.

81. Louisiana 2, ss 123-126: the *in vitro* embryo is a legal person, and may take or be subject to legal action through a guardian.

82. Queensland 3, rec. B(3) (xix), Victoria 1, ss 9 to 13A; Denmark 1, recs 6.1 and 7.1 at 124-25, reg. 3.1 at 132; Council of Europe 1 at 21-22 and guidelines 4 and 9(3); United States 2 at 60S, and United States 1, guideline VII(C); France 5, s. 10 — France 2, L. 668-5; United Kingdom 4, guidelines 15 and 16 and United Kingdom 6, para. 55; British Columbia 1, recs 9 and 10, Canada 3 at 27, rec. 3.4, Ontario 1, rec. 12, and Canada 4 at 9-11.

the gametes may be used, stored or destroyed,[83] and that consent to storage include the respective wishes of each partner in the event of death, disagreement or divorce.[84]

Control over gametes can also be regulated through specific provisions. When the producer dies, at the end of the storage period or if the producer cannot be located, three options are open: the gametes can be destroyed;[85] control can revert to the storing agency, which must comply with the expressed wishes of the producer;[86] or the gametes may be used or destroyed at the discretion of the storing agency.[87]

With respect to stored embryos, the same three options are open when the couple dies, at the end of the storage period, in case of disagreement, or if the couple cannot be located: the embryos may be destroyed;[88] control may revert to the storing agency, which must comply with the wishes of the couple;[89] or the embryos may be used or destroyed at the discretion of the storing agency.[90] If only one of the partners dies, the embryos are destroyed[91] or control reverts to the surviving partner.[92]

According to the report of the Ontario Law Reform Commission, an embryo produced by a donor and one of the partners would be subject to the exclusive control of the couple. Control of an embryo produced from two donations would rest with the agency that has the embryo in its possession until the embryo is implanted in the woman for whom it was produced.[93]

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83. South Australia 2, s. 10(3); Victoria 1, ss 11 to 13A and New South Wales 3, para. 10.18, rec. 26; Spain 1, s. 5; France 5, s. 10 — France 2, L. 668-11 and L. 668-12; United Kingdom 2, appendix 3, ss 2, 3, 6 and 8, United Kingdom 4, guideline 15d), and United Kingdom 6, para. 55; Ontario 1, recs 13 and 14; Canada 5 at 31, rec. 14.

84. United States 2 at 60S; United Kingdom 2, appendix 3, ss 2 and 3, and United Kingdom 6, para. 60; Canada 5 at 40, rec. 24; Quebec 5, recs 47 and 48.

85. Denmark 1 at 97 and rec. 6.1 at 124; Council of Europe 1 at 23-24 and guideline 7; France 5, s. 10 — France 2, L. 668-3; United Kingdom 2, s. 14, and United Kingdom 6, para. 57; Quebec 1, rec. 9. *Contra*: Quebec 5 at 49, rec. 35.

86. New South Wales 3, para. 10.18, and rec. 26; United Kingdom 6, para. 57.

87. United Kingdom 5, para. 10.8, rec. 60 at 86.

88. New South Wales 4, recs 2 and 22; Denmark 1, rec. 6.1 at 124; Council of Europe 1 at 24-25 and guideline 8; France 5, s. 10 — France 2, L. 670; United Kingdom 2, s. 14, and United Kingdom 6, paras 57, 58 and 60; Ontario 1, rec. 32; Quebec 1 at 34.

89. United Kingdom 6, paras 57, 58 and 60. See also New South Wales 4, para. 5.51, which calls for the status quo until the end of the storage period in cases of disagreement.

90. New South Wales 4, recs 2 and 26; United Kingdom 5, para. 10.10, rec. 32 at 83; Ontario 1, rec. 27(1). See, however, Quebec 5, rec. 48, where an ethics committee would decide the fate of the embryos if the couple could not be located, if there were disagreement or if the parental plan were abandoned.

91. Denmark 1 at 101, rec. 6.1 at 124; France 5, s. 10 — France 2, L. 670; United Kingdom 6, para. 60.

92. New South Wales 4, recs 2 and 25; United Kingdom 5, para. 10.12, rec. 33 at 83, and United Kingdom 6, para. 59; Ontario 1, rec. 27(1).

93. Ontario 1, recs 27(1) and 27(2).

As a rule, explicit consent to any use of gametes and embryos is required, and the wishes expressed by the producers must be respected.[94] The conditions stated at the time gametes are donated may also apply to any embryos produced with those gametes,[95] but an unconditional donation deprives the donor of all control over the use of his or her gametes and any embryos that may result.[96]

The Council of Europe permits donations accompanied by reasonable, non-discriminatory conditions,[97] whereas the Barreau du Québec opposes any donation that includes conditions with which the recipient or couple must comply.[98] Donations to a specific person are sometimes prohibited,[99] but in other jurisdictions there is no objection where regular safety precautions are taken.[100] Consent can generally be changed or withdrawn before the donation is used,[101] although some countries consider it to be irrevocable.[102]

(b) Use of Gametes

Gamete donation is often restricted. The laws of Sweden and Norway prohibit the donation of ova and sperm for in vitro fertilization.[103] The Barreau du Québec would permit the donation of gametes where they are to be used for therapeutic purposes.[104] The Council of Europe states that for purposes of IVF it is preferable to use gametes from the couple.[105] One Quebec report suggests prohibiting ovum donation,[106] while another would place restrictions on such donations: the ovum could not be retrieved solely for the purpose of being donated, and the ovum must come from a woman who is undergoing

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94. New South Wales 1, s. 13, New South Wales 4, recs 2, 23 and 24; Victoria 1, ss 9 to 13A; Denmark 1, rec. 4.1 at 123, reg. 4.2 at 132; Spain 1, ss 13 to 15; Council of Europe 1 at 25, and guidelines 8(3) and 17(2); United States 2 at 36S and 60S, Louisiana 2, ss 126 and 130; France 5, s. 10 — France 2, L. 668-12, L. 668-13, L. 669, L. 671, L. 672 and L. 676-2; United Kingdom 2, appendix 3, s. 5, United Kingdom 4, guidelines 5 and 6, and United Kingdom 5, para. 11.24, recs 13 and 14 at 81, United Kingdom 6, paras 51 and 56; Germany 1, s. 4; Ontario 1, rec. 12; Canada 2, rec. 10(b); Quebec 1, recs 23, 25 and 27, and Quebec 5, recs 45, 47 and 50.

95. Council of Europe 1, guideline 17(2); United Kingdom 2, appendix 3, ss 2 and 6; Ontario 1, recs 13, 26 and 27(2).

96. New South Wales 3, para. 10.13, and New South Wales 4, rec. 23; Ontario 1, rec. 27(2).

97. Council of Europe 1 at 25 and guideline 9(3); for example, using gametes in another geographic region.

98. Quebec 1 at 24.

99. United Kingdom 4, guideline 13(j), which advises against gamete donations from known persons or close relatives; France 5, s. 10 and p. 25 — France 2, L. 668-7; Quebec 1 at 24.

100. New South Wales 3, para. 8.4; Victoria 1, s. 16; United States 2 at 49S-50S and 52S; United Kingdom 5, para. 6.7; see also Quebec 5 at 43.

101. Victoria 1, ss 11 to 13A and 15; Council of Europe 1, guideline 9(3); United Kingdom 2, appendix 3, s. 4, United Kingdom 4, guideline 15(b), and United Kingdom 6, para. 57; Ontario 1, recs 13 and 14.

102. South Australia 3 at 25; Denmark 1 at 99. See also Spain 1, s. 5, where the subsequent sterility of the donor is the only ground for revocation; the donor must then repay the costs incurred by the recipient.

103. Sweden 2, s. 2; Norway 1, s. 12.

104. Quebec 1 at 23.

105. Council of Europe 1 at 26 and guideline 11(1). See also Denmark 1, recs 7.1a and 7.1b at 125 (minority proposal).

106. Quebec 4 at 17, rec. 3.1.

infertility treatment and has enough ova to meet her own needs.[107] Finally, many jurisdictions require, or at least recommend, that sperm from only one donor be used for insemination in any given cycle.[108]

The use of gametes from minors is generally discouraged.[109] Ontario, however, does not object to sperm donations from minors but would not allow ovum donation unless there were informed consent and the ovum were donated at the time of a hysterectomy or other operation.[110] By and large, experimentation on gametes does not raise any problems.[111]

(c) Use of Embryos

Some countries are opposed to embryo donation,[112] while others make embryo donation subject to specific conditions: donors must have resolved their fertility problems, and the recipient couple must be in treatment;[113] donation must be restricted to special circumstances, in particular preventing the embryo from being destroyed or undergoing experimentation,[114] unless consent to donation is given prior to fertilization.[115]

The creation of embryos is often limited to procreation[116] or treatment for the couple; embryos cannot therefore be created solely for the purpose of being donated.[117] Implantation in the same person of embryos from different donors would be permitted by the Ontario Law Reform Commission,[118] but is rejected by some countries.[119]

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107. Quebec 5, recs 50 and 51; see also Germany 1, ss 1(1)i and ii.

108. New South Wales 3, para. 9.24, recs 22 and 23; Victoria 1, s. 26; Spain 1, s. 20; Sweden 3; Canada 3, rec. 3.5; Quebec 4, rec. 2.8, Quebec 5, rec. 26, and Quebec 6 at 60.

109. Queensland 3, rec. B(3)(iii); Victoria 1, s. 25 (unless the minor is married); Spain 1, s. 5.

110. Ontario 1, recs 10 and 11.

111. See, *e.g.*, Spain 1, s. 14, and Spain 2 at 238 (gametes that have been subjected to experimentation cannot be used subsequently for procreation); see also Canada 5 at 43-45, rec. 27.

112. Norway 1, ss 3 and 12, and Sweden 2, s. 2. See also Denmark 1, rec. 7.1a at 125 (minority proposal); Germany 1, s. 1(1)v, does not permit the creation of surplus embryos.

113. Louisiana 2, s. 130; France 5, s. 10 — France 2, L. 671 and L. 676; Quebec 1 at 32-33.

114. Council of Europe 1 at 26-27, and guidelines 11 and 12; Quebec 1, rec. 24 at 39.

115. Victoria 1, s. 13. The couple must have received counselling when they gave their consent to the donation. The minister may also authorize donation if the producers of the gametes are deceased or cannot be located (s. 14).

116. Spain 1, ss 3 and 20, and Spain 3 at 243; Louisiana 2, s. 122; Germany 1, ss 1 and 2; Quebec 6 at 61. See also Denmark 1, rec. 7.1c at 125 (minority proposal).

117. Council of Europe 1 at 24-25 and guideline 8(1); France 5, s. 10 — France 2, L. 669; Quebec 1 at 32, recs 22 and 26, and Quebec 5, rec. 49.

118. Ontario 1, rec. 26.

119. Victoria 1, s. 13; Spain 1, s. 20.

Some jurisdictions are opposed to research on embryos,[120] but most prefer to regulate it. Several types of procedures are prohibited (cloning, use of human gametes with gametes from another species, genetic manipulation, parthenogenesis, ectogenesis[121]), and research must in most cases be approved or authorized by some authority.[122] Experimentation on embryos in vitro is generally permitted only if the objective is therapeutic or preventive,[123] on embryos that do not have the capacity to develop,[124] or if the goal cannot be attained by some other means.[125]

Some countries do not permit experimentation on embryos *in vivo*[126] and prohibit embryos that have been used in research from being implanted in a woman's uterus except to increase the woman's chances of conceiving,[127] or where the experimentation was of a therapeutic nature.[128] Finally, the creation or collection of embryos solely for the purpose of research is often prohibited.[129]

2. Post-Mortem Use of Gametes and Embryos

Post-mortem use of gametes or embryos from a deceased spouse is permitted in some countries.[130] In the United Kingdom, absent a specific provision to that effect in a will,

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120. Denmark 1, rec. 3.1 at 129 (minority proposal); Norway 1, ss 3 and 14; United Kingdom 5 para. 11.18; Quebec 4 at 13, rec. 6.4: the Quebec Status of Women Council recommends a moratorium.

121. See, *e.g.*, New South Wales 4, rec. 13 at 71, and Victoria 1, s. 6; Denmark 1, recs 9.1 and 10.1 at 125-26; Spain 1, ss 14, 15 and 20; Council of Europe 1, guidelines 20 and 21; France 5, s. 10 — France 2, L. 673; United Kingdom 2, s. 3 and appendix 2, s. 3, United Kingdom 4, preamble and guideline 10, United Kingdom 5, para. 12.3, recs 15, 47 and 48 at 81 and 85, United Kingdom 6, paras 37, 39, 41 and 42; Germany 1, ss 5 to 7; Canada 2, rec. 10(f).

122. See, *e.g.*, South Australia 2, s. 14; New South Wales 4, recs 17 to 19; Victoria 1, ss 6 and 29; Denmark 1, rec. 4.1 at 123 and recs 12.1 to 13.2 at 127; Spain 1, ss 14 and 15, and Spain 2 at 238; Council of Europe 1, guideline 17(2); France 5, s. 10 — France 2, L. 673; United Kingdom 2, s. 11 and appendix 2, s. 3, United Kingdom 4, guideline 5, and United Kingdom 5, paras 11.18 and 12.16, recs 11, 43 and 49 at 81, 84-85; Ontario 1, rec. 29; Canada 2, rec. 10(e), Canada 5 at 43-45, rec. 27; Quebec 6 at 61.

123. See, *e.g.*, South Australia 2, para. 14(2); Victoria 1, s. 9A; Denmark 1, rec. 4.1 at 123; Spain 1, ss 12 and 16; Council of Europe 1, guideline 17(1); Illinois 1, para. 6(7); United Kingdom 2, appendix 2, s. 3, and United Kingdom 4, guideline 3; Quebec 1 at 33-34, rec. 27.

124. See, *e.g.*, Spain 1, s. 15, and Spain 2 at 238.

125. See, *e.g.*, Denmark 1, rec. 4.1 at 123; Spain 1, ss 15 and 16; Council of Europe 1, guideline 17(2); United Kingdom 4, guideline 2.

126. See, *e.g.*, Council of Europe 1, guideline 19.

127. See, *e.g.*, New South Wales 4, para. 5.24 and rec. 16; Denmark 1, rec. 9.1 at 125; Council of Europe 1, guideline 18; United Kingdom 4, guideline 4, and United Kingdom 5, para. 11.22, rec. 46 at 85; Quebec 1, rec. 27 at 40.

128. Ontario 1, rec. 30; Spain 1, ss 12 to 16.

129. See, *e.g.*, Denmark 1, rec. 9.2 at 126; Spain 1, ss 3 and 20; Council of Europe 1, guideline 16; Louisiana 2, s. 122; France 5, s. 10 — France 2, L. 669; Quebec 1 at 32, and recs 22 and 27 at 39-40. *Contra*: New South Wales 4, rec. 14; Victoria 1, s. 9A; United Kingdom 2, appendix 2, s. 3, and United Kingdom 5, para. 11.30, rec. 45 at 85. See also Germany 1, s. 1(1)v.

130. New South Wales 3, para. 12.4, recs 28 and 29, New South Wales 4, recs 38 and 39; Spain 1, s. 9, Spain 2 at 237, and Spain 3 at 243; United Kingdom 2, s. 28(6). See also United Kingdom 5, paras 4.4, 10.9 and 10.15 and United Kingdom 6, paras 59 and 60, where this practice is discouraged. Ontario 1, recs 20 and 21; Quebec 5, rec. 35.

the procedure must take place before death for filiation between the child and the deceased spouse to be established.[131] In Spain, filiation between the deceased father and the child is possible only if fertilization occurred within six months of death and the father recognized the unborn child in a will or other notarized document.[132] In Australia, a child conceived by means of AI or IVF after the death of a producer is not entitled to inherit unless a specific bequest is made, but has recourse against the estate under another statute.[133] Finally, the Ontario Law Reform Commission recommends that, absent a specific bequest of course, a child be entitled to inherit as long as the child was conceived before the designation of beneficiaries.[134]

Countries that oppose the post-mortem use of gametes and embryos claim that such use is at odds with the welfare of the child, who would be missing a parent.[135]

E. Parentage

The parentage of children born as a result of gamete or embryo donation is dealt with more frequently than that of children born of a surrogate.[136]

1. Gamete and Embryo Donation

Many countries state that gamete donors are in no way linked through filiation or parental responsibility to children born as a result of their donations.[137] However, some jurisdictions limit the application of this principle to cases where the donation is made

131. United Kingdom 2, para. 28(6), United Kingdom 5, paras 10.9 and 10.15, recs 61 and 64 at 86, and United Kingdom 6, paras 59, 60 and 88.

132. Spain 1, s. 9.

133. New South Wales 1, ss 3 and 5A, New South Wales 3, para. 12.4, recs 28, 29 and 31, and New South Wales 4, rec. 38.

134. Ontario 1, recs 20 and 21.

135. Denmark 1 at 97 and 101, rec. 6.1; Council of Europe 1 at 24 and guideline 7(4); France 5, s. 10 and p. 27 — France 2, L. 668-3; Sweden 3 and Sweden 4 at 5. See also Germany 1, s. 4: para. 4(1): [Translation] "Anyone will be punished with up to three years imprisonment or a fine, who ... iii knowingly fertilises artificially an egg cell with the sperm of a man after his death." Quebec 1 at 21 and rec. 6 at 38, Quebec 4 at 12, and Quebec 5, rec. 35.

136. See also the section dealing with the post mortem use of gametes and embryos.

137. South Australia 1, s. 10e; Western Australia 1, s. 7; New South Wales 1, s. 6; Queensland 1, ss 15 to 18; Tasmania 1, s. 10c; Northern Territory 1, ss 5D, 5E and 5F; Victoria 2, ss 10c to 10f; Denmark 1 at 96; Spain 3 at 243; Council of Europe 1 at 28-29 and guideline 14; New York 1, para. 2(b); Missouri 1, s. 210.824; France 5, s. 11 —France 3, s. 342-9; Norway 1, para. 15(2) (by amendment to the *Children Act*); United Kingdom 2, s. 28, United Kingdom 5, paras 4.22, 6.8 and 7.6, recs 52 and 55 at 85, and United Kingdom 6, para. 88; British Columbia 1, recs 1 and 13; Ontario 1, recs 19(2) and 21; Saskatchewan 1 at 9 and s. 4; Canada 2 at 14 and rec. 1, and Canada 5 at 33-34, rec. 18; Quebec 1, recs 12 and 13 at 38, Quebec 5, recs 24 and 25, Quebec 6 at 60, and Quebec 7, art. 579.

under medical supervision or through an authorized centre.[138] A recent statute in the United Kingdom provides that the sperm donor must have consented to the donation so as not to be considered the father of the child.[139]

Legal maternity is often established through a presumption that the woman who gives birth to a child is the child's legal mother.[140] The Ontario Law Reform Commission recommends that the woman who carries the child with the intent of raising it be recognized conclusively as the mother.[141] Spanish law provides that married couples who consent to the procedure cannot challenge maternal filiation.[142]

The husband of the woman who gives birth to the child is recognized as the child's legal father, either by presumption or as a result of his consent to the procedure,[143] which consent is presumed until proven otherwise in many countries.[144] Finally, according to the Law Reform Commission of Saskatchewan, consent could be given before or after insemination.[145]

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138. In Europe, where the donation is not made through an authorized centre, the donor retains parental obligations and a filial relationship with the child may be established: Council of Europe 1 at 29, guideline 14(3). See also Saskatchewan 1, ss 2 and 4.

139. United Kingdom 2, para. 28(6).

140. Commonwealth of Australia 1, s. 60B; South Australia 1, s. 10c; Western Australia 1, ss 5 and 7; New South Wales 4, rec. 37; Queensland 1, s. 17; Tasmania 1, s. 10c; Northern Territory 1, s. 5C; Victoria 2, s. 10E; Spain 3 at 242; Council of Europe 1 at 28-29, guideline 14; Arkansas 1, s. 9-10-201; United Kingdom 2, s. 27, United Kingdom 5, paras 6.8 and 7.6, recs 55 and 56 at 85-86, and United Kingdom 6, para. 88; Canada 2, rec. 2; Quebec 1, recs 13 at 38, and Quebec 5, rec. 34.

141. Ontario 1, rec. 19(1).

142. Spain 1, s. 8.

143. Commonwealth of Australia 1, s. 60B; South Australia 1, s. 10d; Western Australia 1, s. 6; New South Wales 1, s. 5; Queensland 1, ss 15 to 17; Tasmania 1, s. 10c; Northern Territory 1, s. 5D; Victoria 2, ss 10C to 10E; Spain 3 at 242; Council of Europe 1 at 29, guideline 14(2); New York 1, s. 1; Missouri 1, s. 210.824; Arkansas 1, s. 9-10-201; France 5 at 29 (in accordance with ordinary law, France 3, s. 312); Norway 1, para. 15(2) (by amendment to s. 9 of the *Children Act*); United Kingdom 2, s. 28, United Kingdom 5, paras 4.17, 4.24, 4.25 and 7.6, recs 51, 54 and 56 at 85-86, and United Kingdom 6, paras 88 and 89; British Columbia 1, recs 1 and 17; Canada 3, rec. 1; Ontario 1, rec. 19(1); Saskatchewan 1 at 8 and ss 2(a) and 3; Canada 2, rec. 3; Quebec 1 at 25 and recs 11 and 12 at 38, Quebec 5, rec. 33, and Quebec 7, arts 580 and 581. Sweden and some 30 American states have adopted similar legislation, based on the *Uniform Parentage Act* (see United States 5 at 244).

144. Commonwealth of Australia 1, s. 60B; South Australia 1, ss 10a and 10d; Western Australia 1, ss 3, 5 and 6; New South Wales 1, ss 3 and 5; Queensland 1, ss 13 and 15 to 17; Tasmania 1, s. 10c; Northern Territory 1, ss 5A and 5D; Victoria 2, ss 10A, 10C, 10D and 10E; United Kingdom 5, para. 4.24, rec. 54 at 85, and United Kingdom 6, paras 88 and 89 (proposed amendment to the *Family Law Reform Act* 1987, to include ovum and embryo donations); Ontario 1, rec. 19(3); and Canada 2, rec. 3.

145. Saskatchewan 1 at 8 and s. 3.

In most countries, if the couple is not married the *de facto* husband can generally be recognized as the father of the child if he consented to the procedure.[146] According to the Ontario Law Reform Commission's proposal, the husband or partner of a woman who carries a child with the intention of raising it would be deemed conclusively, if he consented, to be the child's legal father.[147]

Disavowal or contestation of paternity is normally carried out by proving the absence of consent or the fact that the child was born naturally, not as a result of a technology.[148] In France, a partner who consented but no longer recognizes the child once the child is born remains responsible to the mother and child. Further, it is impossible for anyone, the child included, to challenge this filiation on the grounds that there is no biological link.[149]

A child born as a result of medically assisted procreation has the same rights as a legitimate child or a child conceived naturally if the couple that used the technologies is married and the husband gave his consent.[150] Some countries specify that insemination must have been performed under medical supervision,[151] while others require that the birth certificate give no indication as to the method of conception.[152]

2. Surrogacy

Many countries that attempt to discourage surrogate motherhood recommend that the presumption attributing legal maternity to the woman who gives birth be applied to surrogacy contracts.[153] Spanish law does not allow a woman to enter into a contract in advance in order to renounce her maternal filiation.[154] The report of the Barreau du Québec states that no preferential right of adoption should be granted to the spouse of

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146. Commonwealth of Australia 1, s. 60B; South Australia 1, ss 10a and 10d; Western Australia 1, ss 3, 5 and 6; New South Wales 1, ss 3 and 5; Queensland 1, ss 13 and 15 to 17; Northern Territory 1, ss 5A and 5D; Victoria 2, ss 10A, 10C to 10E; Spain 1, s. 6, and Spain 3 at 242; Council of Europe 1, guideline 14(2); United Kingdom 2, s. 28; Canada 2, rec. 3; Quebec 5, rec. 34, and Quebec 7, art. 581.

147. Ontario 1, rec. 19(1).

148. Council of Europe 1 at 29, guideline 14(2); Louisiana 1, s. 188; United Kingdom 5, para. 4.24, rec. 53 at 85; Ontario 1, rec. 19(3); Quebec 7, art. 580.

149. France 5, s. 11 and pp. 29-30; France 3, ss 342-10 and 342-11.

150. Council of Europe 1 at 28-29; Arkansas 1, s. 9-10-201; France 5 at 29 (legitimate child of husband, France 3, art. 312); Norway 1, para. 15(2); United Kingdom 5, paras 4.17, 4.24 and 7.6, recs 51, 53 and 56 at 85-86, and United Kingdom 6, para. 89; British Columbia 1, rec. 1; Canada 3 at 33-34 and rec. 1; Ontario 1, rec. 21; Saskatchewan 1, s. 3.

151. New York 1, s. 1; Saskatchewan 1, ss 2(a) and (b).

152. New South Wales 3, paras 11.1 to 11.4, New South Wales 4, rec. 41 at 104; Commonwealth of Australia 2, rec. X; Spain 1, s. 7; France 5 at 29; British Columbia 1, rec. 17; Ontario 1, rec. 20; Canada 2 at 16, rec. 4. See, however, United Kingdom 5, paras 4.25, 6.8 and 7.6, and United Kingdom 6, para. 90, which do not seem to reject recording the method of conception in birth records.

153. New South Wales 5, rec. 9 at 60-62; Council of Europe 1 at 28-29 and guideline 14; Spain 1, s. 10; United Kingdom 2, s. 27, and United Kingdom 5, para. 8.20.

154. Spain 1, s. 10, Spain 2 at 237, and Spain 3 at 242.

the biological father.[155] In the United Kingdom, the Interim Licensing Authority recommends that surrogacy by IVF between close relatives be avoided.[156] Finally, some organizations would grant children born as result of this practice the same rights of access to information as adopted children or children born as a result of artificial insemination.[157]

In Arkansas, the biological father and his wife are recognized as the parents of a child born under a surrogacy contract, although the surrogate's name is recorded on the birth certificate.[158] In Michigan, when a dispute arises, the party with physical custody of the child keeps the child until a court, basing its decision on the best interests of the child, determines otherwise.[159]

The report of the Canadian Bar Association, which does not oppose unchallenged gratuitous agreements, recommends that adoption and family laws be amended to facilitate recognition of the social parents as the legal parents in this specific case. No visitation or custody rights would be granted if the surrogate mother refuses to turn the child over, and the surrogate may, if she keeps the child, claim child support from the couple who refuses to adopt.[160] The position and recommendations of the New York Task Force on Life and the Law are similar: in the event of a dispute arising in the performance of a gratuitous agreement, the court must award custody to the surrogate unless there is clear, convincing evidence that the interest of the child would be better served by a different order.[161]

The Ontario Law Reform Commission favours regulating contracts by proposing that maternal and paternal filiation revert to the applicant couple as soon as the child is born. The surrogate could not change her mind; she must turn the child over at that time, if necessary under a court order.[162]

II. Safety of Medically Assisted Procreation Technologies

Practical standards, record keeping and access to information, as well as donor liability and remedies available to the child, are some of the issues addressed by the legislation and reports surveyed, in the context of ensuring the safety of medically assisted procreation.

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155. Quebec 1 at 29-30 and rec. 21 at 39. See also New South Wales 5, rec. 10 at 62-65.

156. United Kingdom 4, guideline 13(k). See also Quebec 5, rec. 58, which opposes the practice of surrogacy contracts with embryo transfer.

157. New South Wales 5, rec. 11; Quebec 4 at 20.

158. Arkansas 1, s. 9-10-201.

159. Michigan 1, s. 722.861, section 11.

160. Canada 2 at 26-33 and recs 9(c) to 9(h); the surrogate would have the same time as in the case of adoption to decide if she wants to keep the child.

161. New York 2 at 136-37, and s. 4 of the *Proposed Surrogate Parenting Act*. The court must also determine visiting rights and child support in relation to the current law. The burden of proof respecting the interests of the child is greater than the preponderance of evidence but less than proof beyond all reasonable doubt.

162. Ontario 1, recs 49 and 56 to 59. See also New York 2 at 99, which cites the Florida bill prohibiting surrogates from revoking their consent to adoption.

A. Practical Standards

Physical risks, limits on the frequency of use of gametes from a single donor and consultation are areas in which standards are often proposed.

1. Physical Risks

To ensure the quality of gametes, the reports recommend that the following measures be mandatory: psychological assessment of the donor and his or her motivation,[163] medical examination of the donor,[164] screening for transmissible or hereditary diseases,[165] genetic screening or family history assessment,[166] blood tests for HIV (human immunodeficiency virus) antibodies,[167] or repetition of HIV screening of the donor at least six months after the donation, before the sperm is used for any purpose.[168]

Some countries require, or at least recommend, that only frozen sperm be used,[169] while others feel it is sufficient to follow the guidelines of the medical profession on the screening and selection of donors.[170]

As to recommendations on the storage of gametes and embryos, the maximum period for storing gametes usually ranges from five to ten years.[171] The freezing of unfertilized

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163. British Columbia 1, rec. 10; Canada 3 at 5, and Canada 4 at 6; Quebec 5, rec. 14.

164. Delaware 1, s. 2801; Ohio 1, s. 3111.33; United States 1, guideline VII, and United States 2 at 45S; United Kingdom 5, para. 4.18; British Columbia 1, rec. 11; Canada 3 at 9-10, Canada 4 at 5, and Canada 5 at 29-30, rec. 12: "The Societies recommend that donors be required to pass genetic and medical screening tests as set by the professional society."

165. Spain 1, s. 5; Council of Europe 1, guideline 5; Ohio 1, s. 3111.33; United Kingdom 5, para. 4.18; Sweden 3; British Columbia 1, rec. 11; Canada 3, rec. 2, and Canada 4 at 5.

166. New South Wales 3, paras 5.12 and 5.15; Queensland 3 at 111; Spain 1, s. 5; Council of Europe 1, guideline 5; United States 1, guideline VII, United States 2 at 45S, and Ohio 1, s. 3111.33; British Columbia 1, rec. 11; Canada 3 at 7-9, rec. 2.2, and Canada 4 at 5-6. See also Quebec 1 at 23, which recommends the adoption of minimum uniform standards for selecting and matching donors.

167. United States 1, guidelines V, VI and VII; United Kingdom 4, guideline 13(h); Sweden 3; Canada 1 at 27, and Canada 4 at 5; Canada 5 at 38-39, rec. 22; Quebec 1 at 23; Quebec 5, rec. 17, and Quebec 6 at 61. The United States and the United Kingdom also recommend screening for hepatitis B.

168. Louisiana 4, s. 1062.1; United States 1, guideline VII; Sweden 3; Canada 4 at 5; Quebec 4 at 13 and rec. 2.7, Quebec 5 at 89-92 and rec. 17, and Quebec 6 at 43-45.

169. Denmark 1 at 97; United States 1, guideline VII(D), United States 2 at 44S; Louisiana 4, s. 1062.1 (except for AIH); United Kingdom 4, guideline 13(i), United Kingdom 5, para. 10.1 and rec. 30 at 83 (except for AIH), and United Kingdom 6, para. 44; Sweden 3; Canada 4 at 5, Canada 5 at 38-39, rec. 22; Quebec 4 at 13 and rec. 2.7, Quebec 5, rec. 17, and Quebec 6 at 61.

170. New South Wales 3, paras 5.12 and 9.11, recs 4, 17 and 18; United Kingdom 5, para. 4.5 (for AIH); Ontario 1, rec. 8 (recommends national consultation, however, to ensure uniformity); Saskatchewan 1 at 3; Canada 2 at 19 (provincial gamete banks would ensure quality of gametes and select donors).

171. Spain 1, s. 11; Council of Europe 1, guidelines 7(2) and 7(3); France 5, s. 10 and p. 23 — France 2, L. 668-3; United Kingdom 2, s. 14, United Kingdom 5, para. 10.8 and rec. 31 at 83, and United Kingdom 6, para. 54. See also Quebec 1, rec. 9 at 38. The reader will find in table 3, *infra* at 206-209, a list of proposed time limits.

eggs is often discouraged.[172] The recommended period for storing embryos ranges from twelve months to ten years,[173] and eggs fertilized in vitro may not be kept for more than fourteen days.[174]

The risks associated with multiple pregnancy, the number of embryos to be implanted and their subsequent reduction have been the subject of some commentary.[175] Further, embryo donation or transfer from one woman's uterus to another's (whether by uterine lavage or any other method) is generally discouraged because of its experimental nature and the risk of pregnancy for the donor.[176]

2. The Frequency of Use of Gametes from a Single Donor

Controlling the number of times gametes from the same donor may be used has been recommended, by restricting either the number of uses or the number of children resulting from the gametes.[177] The objective is to prevent the risk of consanguinity and the

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172. Spain 1, s. 11; United States 2 at 57S; Norway 1, s. 3; United Kingdom 4, guideline 11 (ovum freezing is permitted, but subsequent implantation is prohibited), and United Kingdom 5, para. 10.2 and rec. 9 at 81; Quebec 5, rec. 52.

173. South Australia 2, paras 10(3) and 13(6); New South Wales 4, rec. 2 at 55-56, and rec. 22 at 86; Denmark 1, rec. 6.1 at 124; Spain 1, s. 11; Council of Europe 1, guideline 8(2); France 5, s. 10 — France 2, L. 670; Norway 1, s. 3; United Kingdom 2, s. 14, United Kingdom 4, guideline 8, United Kingdom 5, para. 10.10, rec. 32 at 83, and United Kingdom 6, para. 54; Ontario 1, rec. 32; Canada 2, rec. 10(g); Quebec 1 at 32-34, Quebec 5, rec. 46.

174. South Australia 2, paras 10(3) and 13(6) (the freezing period may not go beyond the point where the embryo would normally be implanted); New South Wales 4, rec. 2 at 55-56 and rec. 15 at 72; Spain 1, ss 15 and 20; Council of Europe 1, guideline 17(2)b); France 5, s. 10 — France 2, L. 672 (seven-day period); United Kingdom 2, s. 3, United Kingdom 4, guidelines 7 and 8, United Kingdom 5, para. 11.22, recs 12 and 45 at 81 and 85, and United Kingdom 6, paras 33 and 34; Ontario 1, rec. 31; Canada 2, rec. 10(c); Quebec 1, rec. 27 at 39-40.

175. Denmark 1 at 100: reduction is permitted if medical circumstances so require; Spain 1, s. 4: embryos are implanted in numbers deemed sufficient for reasonable chances of pregnancy; United Kingdom 4, guideline 12: the number of embryos to be implanted is limited to three; United Kingdom 5, para. 5.4: the number of embryos to be implanted is left to the judgment of the physician; Germany 1, s. 1: the number of embryos to be implanted is limited to three; Ontario 1, rec. 26: no restriction on the number of embryos to be implanted should be imposed; Quebec 5, recs 42 and 43, which accepts implantation of several embryos, but is opposed to reduction.

176. South Australia 2, paras 10(3) and 13(6); Council of Europe 1 at 27, guideline 12; United States 2 at 54S; Spain 1, s. 20; France 5, s. 10 — France 2, L. 669; United Kingdom 5, para. 7.5 and rec. 8 at 81; Germany 1, s. 1; Canada 5 at 24, rec. 8; Quebec 1 at 19 and rec. 4 at 38. *Contra*: Ontario 1 at 146 and rec. 1.

177. Spain 1, s. 5; United States 1, guideline VII(C), and United States 2 at 45S; United Kingdom 5, paras 4.26 and 6.6, recs 23 and 27 at 82-83; British Columbia 1, rec. 12; Quebec 4 at 13, rec. 2.4, and Quebec 5, rec. 22. The following reports recommend a limit but do not set a figure: New South Wales 3, para. 9.15, recs 20 and 21; Denmark 1, reg. 3.1 at 132 (to be determined by the Danish Board of Health); Council of Europe 1, guideline 10; France 5, s. 10 — France 2, L. 668-9 (to be set by order of the Minister of Health); United Kingdom 6, para. 87; Canada 3 at 12 and rec. 2.4; Quebec 1 at 24.

transmission of diseases that current medical expertise does not make it possible to detect.[178] Moreover, the Ontario report proposes to leave the number of times gametes from the same donor may be used to be determined on the basis of the physician's judgment and the wishes of the parties.[179]

3. Counselling

To assist the parties involved in medically assisted procreation programs, counselling is recommended in some countries[180] and mandatory in others.[181] For example, legislation in the state of Victoria makes counselling mandatory before any procedure, including gamete donation.[182]

B. Record Keeping and Access to Information

Record keeping and centralization of information, as well as access to information, have been the subject of numerous recommendations.

1. Record Keeping and Centralization of Information

All jurisdictions agree on the need to keep records, but there are differing opinions as to how they should be kept. Responsibility for keeping records may rest with the physician or the clinic,[183] and in most cases a system that allows the donor's file to be linked with

178. See, *e.g.*, Council of Europe 1 at 25-26.

179. Ontario 1, rec. 16.

180. New South Wales 3, para. 7.11, rec. 13; New South Wales 4, rec. 10 at 67-68; Commonwealth of Australia 2, rec. VII; Denmark 1 at 99; United States 1, guideline IV, and United States 2 at 47S and 60S; United Kingdom 2, para. 13(6) and appendix 3, s. 3, United Kingdom 4, guidelines 13(g) and 15(a), United Kingdom 5, paras 3.4, 6.6 and 7.7, recs 19 and 27 at 82-83, and United Kingdom 6, paras 56, 60 and 77; British Columbia 1 at 10 and rec. 10; Canada 1 at 26-27, Canada 3 at 26 and rec. 3.3, and Canada 4 at 6; Quebec 1 at 24 and rec. 5 at 38, Quebec 4 at 10, recs 1.5, 2.3, 2.5 and 3.1, and Quebec 5 at 58, rec. 36.

181. Victoria 1, ss 9 to 13A, 18; Spain 1, s. 2; Council of Europe 1, guideline 4(2).

182. Victoria 1, ss 9 to 13A, 18. The counsellor must be approved by the minister. The physician conducting the procedure must ensure that the couple, not just the person undergoing the procedure, have received counselling and that follow-up is arranged.

183. South Australia 2, paras 13(3) and (6) (physician); New South Wales 1, s. 16 (physician), New South Wales 3, para. 13.30 and rec. 37 (physician and clinic), and New South Wales 4, recs 27 to 29 at 90-92 (clinic); Council of Europe 1, guideline 6 (physician and clinic); Spain 1, s. 19 (physician); United States 2 at 44S and 76S (physician); United Kingdom 4, guidelines 13(b) and 14(b) (clinic); Canada 3 at 23-24 (physician).

the recipient's but still protects anonymity is recommended.[184] One Australian report recommends that when a child is born as a result of a gamete or embryo donation, records be kept indefinitely.[185]

It is often recommended that a central registry containing the records of donors and children born as a result of medically assisted procreation be established and that physicians and clinics be required to report to this registry.[186] However, there are fears about the risk to anonymity that could result from such a registry.[187]

2. Access to Information

The anonymity of the donor and the parties is a general rule followed by all countries except Sweden,[188] where donor anonymity has given way to the fundamental right of children to know about their genetic origins.[189] Some state that information obtained from donors enjoys the same guarantee of confidentiality as information obtained from patients,[190] and the terms applicable to consent by the parties to the conditions governing access to information are in some cases addressed.[191]

The terms of access to information differ depending on whether the information is identifying or not. Conditions that warrant disclosure of identity vary: if the person

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184. United States 2 at 76S; Ohio 1, s. 3111.36; Sweden 3; British Columbia 1, rec. 16; Canada 3 at 18-25, rec. 3.2; Ontario 1, recs 22(3) and 22(5); Quebec 5, rec. 24, and Quebec 6 at 60.

185. Commonwealth of Australia 2, rec. II. See also Sweden 1, s. 3, and Sweden 3: records are kept for 70 years.

186. Victoria 1, s. 22; Queensland 3, recs B(3) (xi) and B(3) (xii); Commonwealth of Australia 2, recs IV and VIII; Spain 1, s. 5; Pennsylvania 1, s. 3213; United Kingdom 2, s. 31, United Kingdom 4, guideline 13(b), United Kingdom 5, para. 13.9, rec. 16 at 81, and United Kingdom 6, paras 15, 79, 80 and 85; Canada 1 at 27, and Canada 2 at 24-25, rec. 5; Quebec 4 at 25.

187. New South Wales 3, para. 13.30, rec. 37, and New South Wales 4, para. 5.52; Canada 3 at 23.

188. New South Wales 1, s. 14, New South Wales 3, paras 8.2 and 8.13, recs 14 and 16, and New South Wales 4, rec. 34 at 97; Queensland 3, rec. B(3) (xiii); Victoria 1, s. 23; Commonwealth of Australia 2, rec. I; Denmark 1, rec. 8.1 at 125 and reg. 5.1 at 133; Spain 1, ss 2, 5, 19 and 20; Council of Europe 1, guideline 13; United States 1, guideline VII(c), and United States 2 at 44S, 50S, 52S, 75S and 76S; France 5, s. 10 — France 2, L. 668-8, and France 4, s. 378; Norway 1, s. 10; United Kingdom 2, ss 31 to 33 and s. 41, United Kingdom 4, guideline 13(j), United Kingdom 5, paras 3.2, 6.6 and 7.7, recs 18 and 27 at 82-83, and United Kingdom 6, paras 83 and 84; British Columbia 1, recs 1 and 9; Ontario 1, rec. 22(4); Saskatchewan 1 at 10 and s. 5(1); Canada 2 at 24, and Canada 4 at 10; Quebec 1, recs 15 and 16 at 38-39, Quebec 5, recs 29 and 31, and Quebec 7, art. 583.

189. Sweden 1, s. 4, and Sweden 5 at 389: the child has a right of access to the donor's complete file when he is deemed sufficiently mature. See also Denmark 1, rec. 8.1a at 125, and reg. 5.1a at 132, where a minority of the members shared this view in cases of gamete or embryo donation.

190. New South Wales 1, s. 14, New South Wales 3, paras 8.13 and 14.10, and New South Wales 4, rec. 34 at 97; Ontario 1, rec. 22(2).

191. See, *e.g.*, Commonwealth of Australia 2, rec. VII: the parties must give their formal consent to the conditions of access to information before any procedure. Quebec 6 at 60: the donor must be informed of the type of information to which the child may have access; see also Sweden 3.

consents;[192] if there is reasonable cause or in extreme cases;[193] pursuant to a ruling by a specific authority;[194] if there is a risk to life or health;[195] as part of the requirements of the agency that performs the technologies or conducts research; and finally, in connection with enforcement of the law.[196] Further, anonymity could be removed in the future in circumstances that have yet to be determined.[197] Others already grant children who have reached the age of majority access to identifying data on request.[198]

Children may be granted access to non-identifying information in donors' files when they reach the age of 18,[199] when they reach the age of 14,[200] or regardless of their age.[201]

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192. South Australia 2, s. 18; New South Wales 1, s. 15 (the right of access is denied to children under 18 years of age, unless they are married), New South Wales 3, paras 8.2 and 13.23, recs 15 and 32, and New South Wales 4, rec. 31 at 92-93; Victoria 1, s. 22; Commonwealth of Australia 2, rec. VII, option 2 (the right of access may be exercised only where the child is 18, by written request from a person with a legitimate interest, and the parents must consent if the information requested concerns the child); Canada 5 at 35-37, recs 19 to 21; Quebec 5, recs 31 and 32 (the donor has a right to refuse the disclosure of his or her identity, and the parents may refuse on behalf of the child if he or she is unaware of the method of his or her conception).

193. Commonwealth of Australia 2, rec. VII; United States 2 at 44S; Quebec 1, recs 14 to 16 at 38-39.

194. New South Wales 1, s. 15, New South Wales 3, para. 8.2, rec.15, and New South Wales 4, rec. 31 at 92-93 (on permission of the biomedical council); Commonwealth of Australia 2, rec. VII; Spain 2 at 237 (in the context of legal proceedings); Sweden 1, s. 5 (in the context of legal proceedings where paternity is in dispute); Canada 2, rec. 6 (court order allowing access to provincial registry); Quebec 5, recs 29 and 32 (access to physician and donor allowed where medical reasons so require, or court order).

195. Spain 1, ss 5 and 8 (proven danger to the life of the child; however, the disclosure of identity does not prove legal paternity); Canada 2, rec. 6 (access to provincial registry would be allowed only in cases of medical necessity); Canada 3 at 27 (congenital or hereditary disease of the child where this information affects the donor's health); Saskatchewan 1 at 12 and s. 5 (for AID, the information may be consulted by physicians and medical staff or under their supervision; the information is admissible as evidence in legal proceedings provided that the identity of the donor is not revealed); Quebec 1 at 27, and recs 15 and 16 at 38-39 (on permission of the court, if to save human life or prevent major psychological problems in the child; however, direct contact is not mandatory); Quebec 5, recs 29 and 32 (access to physician and donor allowed if necessary for medical reasons), and Quebec 7, art. 583.

196. South Australia 2, s. 18; New South Wales 1, s. 15, New South Wales 3, para. 8.2, rec.15, and New South Wales 4, rec. 31 at 92-93.

197. Council of Europe 1, guideline 13 (member states may adopt legislation permitting access to the donor's identity and the method of conception); United Kingdom 6, para. 84; Quebec 6 at 60-61; Victoria 4, paras 3.14 and 3.36; New South Wales 4, rec. 32 at 95.

198. Commonwealth of Australia 2, rec. VII, option I; United Kingdom 2, s. 31; Quebec 4 at 13 and rec. 2.9. For more details, see Quebec 2.

199. New South Wales 5, rec. 11 at 66-67; United Kingdom 5, paras 4.21, 6.6 and 7.7, recs 20 and 27 at 82-83, and United Kingdom 6, para. 83. See also Spain 1, ss 5 and 19.

200. Quebec 4 at 13 and rec. 2.9; Quebec 5, rec. 28.

201. New South Wales 1, s. 17 (a person having "good cause" based on welfare of health of a party may have access to the information upon simple agreement with the holder of the records), New South Wales 3, para. 13.23 and rec. 33, and New South Wales 4, recs 30, 32 and 33 at 92-95 (the information may be disclosed to the child, the donor or any person providing evidence of a "good cause" or pursuant to a decision by the biomedical council); Victoria 1, ss 20 and 23 and appendix 7; Commonwealth of Australia 2, rec. VII (written request to state registry by a person with legitimate interest or by the parents of the child if the child is a minor); United States 1, guideline VII(c), and United States 2 at 44S; United Kingdom 2, s. 31 (the information that may be disclosed to a minor is limited to the existence of a genetic link with potential spouse; counselling must be offered); Ontario 1, rec. 22(7) (the issue would be left to the discretion of the attending physician); Canada 5 at 35-37, recs 19 to 21; Quebec 6 at 60.

However, some require a medical reason, such as the discovery of a genetic or hereditary disease.[202] Finally, it is sometimes stated that the decision to tell the child about his or her origins is a private matter.[203]

C. Liability of Donors and Remedies Available to Children

In some countries, donors who intentionally conceal necessary information or give false information are guilty of an offence.[204] However, France's draft bill states that donors have no liability *vis-à-vis* the child.[205]

With respect to civil remedies, the creation of a specific remedy for children who have sustained injury is generally not recommended because the physician continues to be subject to the rules of tort law.[206]

Finally, it should be noted that the report to the Minister of National Health and Welfare looks at the possibility of creating an agency to review any court actions resulting from the birth of a child with a congenital deformity or serious genetic disease.[207]

III. Medical Control and Regulation

Uniform state, provincial or national legislation or regulations are recommended in a number of jurisdictions,[208] while others prefer to leave some matters to the professional

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202. Council of Europe 1, guideline 13; British Columbia 1, rec. 16.

203. See, *e.g.*, Commonwealth of Australia 2, rec. I; Canada 3 at 26, and Ontario 1, rec. 22(7); Quebec 5, rec. 24.

204. New South Wales 1, s. 11, New South Wales 3, para. 5.18, rec. 5, and New South Wales 4, rec. 35 at 98; Victoria 1, s. 27; Ontario 1, rec. 23. See also United States 2 at 24S (moral duty rather than offence); Canada 3 at 23 (protection of donor anonymity is conditional on donor disclosing genetic and medical information that to the best of his or her knowledge is accurate).

205. France 5, s. 11 — France 3, s. 342-9.

206. New South Wales 3, para. 14.9, rec. 41, and New South Wales 4, rec. 11 at 69; Spain 1, s. 19; British Columbia 1, recs 1 and 15; Ontario 1, recs 22, 24 and 25; Saskatchewan 1 at 4-5.

207. Canada 3 at 22.

208. See, *e.g.*, New South Wales 3, para. 5.12, rec. 4 (recruitment and screening of donors); Ontario 1, rec. 9 (recruitment and screening of donors); Canada 3, rec. 2 and p. 15 (acquisition, storage and import of human sperm); Canada 2, rec. 10(e) (research); Canada 5 at 39, rec. 23: "The Societies endorse the facilities for the screening, storage and ultimate disposition of frozen donor sperm. Such facilities should be *required by law* to adhere to standards as provided by professional societies such as CFAS for the medical/genetic screening of donors, screening of semen for STD and record keeping." [emphasis added]; Quebec 1, rec. 2 at 37.

judgment of physicians,[209] ethics committees[210] and working groups.[211] It has also been recommended that some issues be studied,[212] but most recommendations deal with medical control and regulation of technologies.

A. Medical Control

There is a definite need for medical control of medically assisted procreation. Legislation provides that the technologies are to be performed by physicians or specialists or under their supervision, or in hospitals or authorized centres.[213] The reports require the medical supervision or intervention of a physician, on the ground that medically assisted procreation technologies are a part of medical practice[214] and, as such, must be carried out in authorized centres or clinics.[215]

With respect to the storage, transfer and import of gametes and embryos, British Columbia recommends the creation of a government-controlled institutional sperm

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209. See, *e.g.*, New South Wales 3, recs 7, 12, 17 and 36 (consent forms, counselling, screening tests, record keeping); United States 2 at 75S-80S; Ontario 1, recs 16 and 24 (frequency of use of gametes from a single donor and access to non-identifying information); Saskatchewan 1 at 3.

210. See, *e.g.*, New South Wales 4, recs 1, 2 and 21 and paras 5.9 to 5.11 (code of ethics for storage and utilization of embryos created by IVF); United States 2 at 77S; United Kingdom 4, guidelines 13(a) and 14(a) (every centre must have access to a multidisciplinary ethics committee that includes women to approve the technologies used); Sweden 5 at 389 (research and experimentation).

211. See, *e.g.*, United Kingdom 5, para. 2.17 and rec. 38 at 84 (national working group made up of health services representatives and practitioners to establish guidelines for organization of services); Quebec 5, recs 60 and 61 (multidisciplinary task force to study embryo research and suggest guidelines to Minister of Health).

212. See, *e.g.*, United States 2 at 75S (long-term impact on patients); Canada 1 at 27-28 (infertility, impact of mutagenic factors, origins of male factor infertility, screening programs for chlamydia and gonorrhea), and Canada 3, rec. 2.5 (long-term effects of donor selection criteria); Quebec 5, recs 6, 19 and 44 (causes of and treatments for infertility, contraceptives, alternatives to early voluntary sterilization, improvement of success rates with frozen sperm, risks of multiple pregnancy in relation to number of embryos implanted, improvement of chances of pregnancy with only one embryo transferred); Quebec 6 at 60 (infertility, fertility, contraceptives, alternatives to early sterilization).

213. South Australia 2, s. 13; New South Wales 1; Victoria 1, ss 7, 9 to 13A and 17; Spain 1, ss 18 to 20; Louisiana 2, s. 128; Ohio 1, s. 3111.32; France 1, s. 2; Norway 1, ss 2 and 14; Sweden 1, s. 3, Sweden 2, ss 3 and 4, and Sweden 5 at 388-89; Germany 1, ss 9, 11 and 12.

214. New South Wales 3, para. 4.7, rec. 2, and New South Wales 4, rec. 5 at 62; Denmark 1 at 97 and 99; Council of Europe 1 at 20-21 and guideline 2; United States 2 at 75S-77S; France 5, s. 10 — France 2, L. 668-2 and L. 675; United Kingdom 5, paras 3.1, 4.5 and 13.7, rec. 3 at 80; British Columbia 1, rec. 6; Ontario 1, rec. 3; Canada 2 at 17-18 and rec. 7.

215. South Australia 3, rec. 7; New South Wales 3, paras 4.6 and 4.7, recs 1 and 2, and New South Wales 4, recs 1, 4 and 6; Queensland 3, rec. B(1) (iii); Denmark 1 at 97 and 99; Council of Europe 1 at 20-21 and guideline 2; France 5, s. 10 — France 2, L. 668-2 and L. 675 (for IVF and embryo transfer); United Kingdom 5, paras 4.16, 5.10, 6.6, 7.4 and 13.7, recs 3 to 7 at 80, and United Kingdom 6, paras 15, 20, 21 and 27 (for AID, IVF, ovum donation and embryo transfer); Quebec 4 at 13, recs 2.2 and 6.2, Quebec 5, recs 8, 9, 36, 37 and 64, and Quebec 6 at 60 (limit on number of centres). *Contra*: Ontario 1 at 153 and rec. 4.

bank.[216] The Barreau du Québec would prohibit the creation of embryo banks devoted exclusively to storage for the purpose of donation or experimentation.[217] Most recommendations state that only authorized gamete banks or institutions may engage in such activities.[218]

B. Regulation of Technologies

A number of recommendations have been made concerning regulation of the technologies used in medically assisted procreation.

In New South Wales, it is recommended that the Biomedical Council, a statutory multidisciplinary agency comprising equal numbers of women and men, draw up a code of ethics that would outline the conditions for obtaining licences and set clinical standards and standards for research and the recording of information. The Council's role would be to advise the Minister for Health, inform the public, review the maximum storage period for gametes and embryos, settle disputes over access to information, and approve research projects. The overall authorization system would, however, be administered by the Department of Health.[219] There are no special regulatory provisions in the New South Wales legislation on artificial insemination.[220]

A statute passed by South Australia established the South Australian Council on Reproductive Technology, a multidisciplinary agency comprising equal numbers of women and men. The Council's role is to draft a code of ethics including clinical and research standards; advise the Department of Health on matters relating to medically assisted procreation and the conditions for issuing licences to practise; determine the conditions

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216. British Columbia 1, recs 19 and 21.

217. Quebec 1, rec. 26 at 39.

218. Denmark 1, rec. 6.1 at 124 and reg. 3.1 at 132; Spain 1, s. 20 (trade, import or export of embryos are prohibited); Council of Europe 1 at 20-21 and guideline 2; Delaware 1, s. 2801; France 1, s. 2, France 5, s. 10 — France 2, L. 668-2 and L. 676-4; Norway 1, ss 3 and 14; United Kingdom 2, ss 3, 4 and 41, and appendix 2, s. 2, United Kingdom 5, paras 13.7 and 13.13, recs 3, 17 and 50 at 80, 81 and 85, and United Kingdom 6, paras 27, 48, 49, 62 and 63; Sweden 1, s. 6; British Columbia 1, recs 19 to 21 (the creation of an institutional bank should be preferred over commercial and private banks except those under federal government supervision); Canada 2, rec. 8 (the CBA recommends the creation of provincial gamete banks), and Canada 3 at 14 and rec. 2.5 (import of sperm by commercial banks and creation of private banks outside the jurisdiction of a public agency are prohibited pending the adoption of regulations setting out federal quality standards); Ontario 1, recs 17 and 18 (the OLRC would allow banks to operate on a commercial basis as long as they are subject to government control); Quebec 1 at 25 and rec. 7 at 38.

219. New South Wales 4, recs 1, 2, 4 and 6. Half the members of the Council would be women because the impact of IVF is greater for women. See also New South Wales 3, paras 4.6 and 4.7, recs 1 and 2.

220. New South Wales 1.

for issuing research permits; conduct certain kinds of research; and inform the public and report to the Department and to Parliament. Permits and licences are issued by the Minister for Health.[221]

The legislation passed in the state of Victoria calls for a system of certification of clinics and consultants by the Minister for Health. Research and research permits are controlled by the Standing Review and Advisory Committee, a multidisciplinary agency that advises the government on all matters related to medically assisted procreation and prepares annual reports for Parliament.[222]

The Danish Council of Ethics proposes the establishment of a regulatory agency to handle the approval of research projects and certification of clinics that wish to offer medically assisted procreation services.[223]

In Spain, a statute dealing with all aspects of medically assisted procreation provides for the establishment of a National Commission on Assisted Reproduction. The multidisciplinary agency would advise and work with the government to compile data and establish operating criteria applicable to clinics and services. It may also be called upon to authorize research projects.[224]

In the United Kingdom, the first reports recommended the establishment of an agency separate from the government that would have regulatory power and would be responsible for monitoring and regulating infertility services, the storage of gametes and embryos, research, licences, and a central register of information.[225] As an interim measure, the Voluntary Licensing Authority — now called the Interim Licensing Authority — a body created jointly by the Medical Research Council and the Royal College of Obstetricians and Gynaecologists, carries out the role of this agency by urging centres to seek certification and apply for licences.[226] The new statute adopted in November 1990, the *Human Fertilisation and Embryology Act 1990*, incorporates these recommendations by creating a regulatory agency called the Human Fertilisation and Embryology Authority, which in turn will set up one or more committees to issue and revoke licences and permits. In addition to being in charge of the register of information, the agency will advise licensees and establish a code of practice dealing with the welfare of the child and the conduct of activities related to medically assisted procreation.[227]

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221. South Australia 2, ss 5, 10 to 12; see also ss 13 to 16, regarding the conditions for issuing permits and the powers of the Department.

222. Victoria 1, ss 7 to 9A and 29.

223. Denmark 1, recs 12.1 to 16.1 at 127-28. Regional agencies could also be established, see Denmark 1 at 139-47.

224. Spain 1, ss 14 to 16 and 21. Section 5 calls for the establishment of a central data registry.

225. United Kingdom 5, paras 13.3 to 13.13, recs 1 to 3, 16, 17 and 50 at 80, 81 and 85, and United Kingdom 6, paras 13 to 27, 79 and 85.

226. United Kingdom 6, para. 9. See also United Kingdom 4 at 45 and 49.

227. United Kingdom 2, ss 5, 8, 9, 23, 25 and 31.

In Quebec, the report of the Department of Health and Social Services calls for the development of minimum clinical and ethical standards that would be incorporated in the Department's system of certifying and evaluating clinics. A provincial network of clinics would be set up, and clinics would be responsible for compiling and publishing uniform data on the services provided. Monitoring the evolution of practices would be left to the academic community and to interested agencies.[228] Also, the Status of Women Council suggests that the Department of Health and Social Services set up a multidisciplinary ad hoc committee to supervise the development of certification standards that specialized centres would have to meet, as well as mechanisms for evaluating, monitoring and checking the quality of practices.[229] The government should also set up an ethics advisory body comprising representatives of society at large rather than experts, to advise and express ethical opinions on medically assisted procreation.[230] Finally, enabling legislation should be passed.[231]

In short, the agencies recommended to regulate medically assisted procreation have similar responsibilities and structures.

Although the initiatives taken around the world to identify the issues raised by the technologies used in medically assisted procreation vary in scope, our study of the legislative provisions and recommendations seems to indicate that the advent of these technologies is accepted with at least some reservations and that there is consensus on a number of basic principles.

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228. QUEBEC 5, recs 65 to 76.

229. QUEBEC 4 at 25, recs 6.1, 6.5 and 6.6. The number of certified specialized centres would be limited to five, the number of centres now in existence. At the end of the committee's brief mandate, the recommendations on practical conditions would give way to standards issued by the Department for the recognition of clinics. Periodic monitoring and evaluation would be needed.

230. QUEBEC 4 at 25-26, rec. 6.5. The mandate would include qualitative management of births, evaluation and monitoring of practice and research, and distribution of information to the public. The agency would be given access to the annual reports of certified centres so that it could conduct general evaluations of the services provided. Women should be strongly represented.

231. QUEBEC 4 at 26, rec. 6.6.

TABLE 1: Eligibility for Medically Assisted Procreation Services (Except Surrogacy)

Text*	Unmarried Heterosexual Couple	Single Woman	Women in Homosexual Relationship
NEW SOUTH WALES 1 NEW SOUTH WALES 3 (AI) NEW SOUTH WALES 4 (IVF)	Authorized	Not excluded, restrictive criteria to be considered	—
SOUTH AUSTRALIA 2	Authorized (cohabitation for at least 5 years)	Excluded	Excluded
VICTORIA 1	Authorized	Excluded for IVF	Excluded for IVF
BRITISH COLUMBIA 1	Authorized	Not excluded	Not excluded
CANADA 2	Authorized	Not excluded	—
CANADA 4	Authorized	Authorized	Authorized
CANADA 5	Authorized	Authorized	Authorized
ONTARIO 1	Authorized	Authorized	—
QUEBEC 1	Authorized	Excluded	Excluded
QUEBEC 4	Authorized	Excluded	Excluded
QUEBEC 5	Authorized	Authorized for AI	Authorized for AI
COUNCIL OF EUROPE 1	Authorized	Excluded	Excluded
DENMARK 1	Authorized	Authorized	Authorized
FRANCE 5	Authorized	Excluded	Excluded
NORWAY 1	Excluded	Excluded	Excluded

*See List of Texts Cited, *infra* at 214-20.

TABLE 1: Eligibility for Medically Assisted Procreation Services (Except Surrogacy) (*Concluded*)

Text*	Unmarried Heterosexual Couple	Single Woman	Women in Homosexual Relationship
SPAIN 1	Authorized	Authorized	—
SWEDEN 1 (AI) SWEDEN 3	Authorized	Excluded	Excluded
SWEDEN 2 (IVF)	Authorized	Excluded	Excluded
UNITED KINGDOM 2	Authorized	Not excluded	—
UNITED KINGDOM 5	Authorized	Not excluded, but preference to heterosexual couples	Not excluded, but preference to heterosexual couples
UNITED STATES 1	Authorized	Authorized	—
UNITED STATES 2	Authorized	Authorized (in special circumstances)	—

*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy)

Text*	Infertility or Genetic Disorder	Welfare of Child	Stability	Consent of Partner	Other Criteria	Decision
NEW SOUTH WALES 1 NEW SOUTH WALES 3 (AI) NEW SOUTH WALES 4 (IVF)	Considered for couples	Considered	Considered	—	Need for counselling, physical and psychological health of future parents	By physician — professional sanction if physician fails to consider criteria, even if they are not mandatory
SOUTH AUSTRALIA 2	Required	—	—	—	—	—
VICTORIA 1	1 year of alternative treatment required, except for AI	Required	—	Required, except for AI	Counselling mandatory	By physician
BRITISH COLUMBIA 1	—	—	—	Required for married couples	Parental qualities as for adoption required	By physician according to criteria — appeal possible
CANADA 2	—	—	—	—	—	By physician
CANADA 4	—	—	Required	—	—	—
ONTARIO 1	Required for couples	—	Required	—	—	By physician according to criteria — appeal possible
QUEBEC 1	Infertility required	—	Required for unmarried couples	—	—	—

*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy) (*Continued*)

Text*	Infertility or Genetic Disorder	Welfare of Child	Stability	Consent of Partner	Other Criteria	Decision
QUEBEC 4	Required	—	—	—	—	—
QUEBEC 5	Required	—	—	—	—	—
COUNCIL OF EUROPE 1	Required	Required	—	—	Reasonable chance of success — low risk to mother's or child's health	By physician
DENMARK 1	—	—	—	Required	—	—
FRANCE 5	Required	—	—	Required	Procedure applied by physician or under physician's supervision	Criminal sanction for anyone who violates the criteria established by the preliminary draft legislation
NORWAY 1	Required	—	—	Required	Medical and psychosocial assessment of couple	By physician

*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy) (*Concluded*)

Text*	Infertility or Genetic Disorder	Welfare of Child	Stability	Consent of Partner	Other Criteria	Decision
SPAIN 1	—	—	—	Required for married couples	Reasonable chance of success; good physical and psychological health; woman must be at least 18 years old	—
SWEDEN 1 (AI) SWEDEN 3	—	Required	—	Required	Medical, psychological and social assessment of couple	By physician — appeal possible
SWEDEN 2 (IVF)	—	—	—	Required	—	—
UNITED KINGDOM 2	—	Required	—	—	—	—
UNITED KINGDOM 5	—	—	—	Recommended	—	By physician, who must justify refusal
UNITED STATES 1	—	—	—	Required	—	—

*See List of Texts Cited, *infra* at 214-20.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
NEW SOUTH WALES 1 (AI)	—	—	Fixed amount or reimbursement of expenses (sperm)	—	Prohibited	—
NEW SOUTH WALES 3 (AI)	—	—	Fixed amount and reimbursement of necessary or reasonable expenses (sperm)	—	—	—
NEW SOUTH WALES 4 (IVF)	—	10 years	—	—	—	—
SOUTH AUSTRALIA 2	—	10 years, with annual review (donor)	—	—	—	—
VICTORIA 1	—	—	Travel costs, medical expenses, and other costs	—	Prohibited	Prohibited
BRITISH COLUMBIA 1 (AI)	—	—	Expenses, time, lost wages (sperm)	—	—	—
CANADA 1	—	—	—	—	Forbidden	Forbidden
CANADA 2	—	5 years	—	—	—	—
CANADA 3	—	—	Inconvenience, time, travel costs (sperm)	—	—	—

*See List of Texts Cited, *infra* at 214-20.

**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Continued*)

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
CANADA 4 (AI)	—	—	Expenses and inconvenience (sperm)	—	—	—
CANADA 5	—	—	Expenses and inconvenience	—	If public funding is inadequate, possibility of establishment of profit-oriented banks	—
ONTARIO 1	—	10 years	Reasonable expenses, time and inconvenience; excludes discomfort; may be higher for ovum	—	Commercial banks permitted (according to regulations)	Commercial banks permitted (according to regulations)
QUEBEC 1	To be determined	To be determined	Actual expenses	—	Forbidden	Forbidden
QUEBEC 4	—	—	No payment (sperm)	—	—	—
QUEBEC 5	—	2 years (may be extended in special circumstances)	Reasonable costs, to be borne by recipient (sperm)	—	Forbidden	Forbidden
QUEBEC 6	—	—	—	—	—	Forbidden

*See List of Texts Cited, *infra* at 214-20.
**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Continued*)

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
COUNCIL OF EUROPE 1	To be determined	To be determined	Expenses, travel costs, lost wages	Expenses, travel costs, lost wages	Forbidden	Forbidden
DENMARK 1	—	1 year	—	—	—	Forbidden
FRANCE 5	To be determined	5 years	Expenses, excludes lost wages	—	Profit forbidden	—
NORWAY 1	—	1 year	—	—	—	—
SPAIN 1	5 years	5 years	—	—	—	Forbidden
SWEDEN 1 (AI) SWEDEN 2 (IVF)	—	—	—	—	Profit forbidden	—
UNITED KINGDOM 2	10 years	5 years	—	—	Forbidden	Forbidden
UNITED KINGDOM 4	—	10 years, with review every 2 years	—	—	Forbidden (ovum)	—
UNITED KINGDOM 5	Review every 5 years	10 years, with review every 5 years	Expenses (sperm)	—	Authorized with the approval of the regulatory agency	Authorized with the approval of the regulatory agency
UNITED KINGDOM 6	10 years	5 years	Reasonable costs	Reasonable costs	Authorized with the approval of the regulatory agency	Authorized with the approval of the regulatory agency

*See List of Texts Cited, *infra* at 214-20.

**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Concluded*)

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
UNITED STATES 1	—	—	Expenses and time (sperm)	—	—	—
UNITED STATES 2	—	—	Expenses and time (sperm) Expenses, time, risks and inconvenience (ovum)	Expenses and inconvenience	—	—

*See List of Texts Cited, *infra* at 214-20.
**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 4: Surrogacy*

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
AUSTRALIA 1	Commercialization prohibited	Prohibited	Prohibited	Prohibited	Null
COMMONWEALTH OF AUSTRALIA 3	Permitted under strict control	Controlled	Controlled	—	Null
NEW SOUTH WALES 5	Surrogacy discouraged Commercialization prohibited	Prohibited (including professional and attorney)	Prohibited	Prohibited	Null
QUEENSLAND 2	Surrogate motherhood prohibited	Prohibited	Prohibited	Prohibited	Null
SOUTH AUSTRALIA 1	Commercialization prohibited	Prohibited if payment	Prohibited	Prohibited for intermediaries	Null
VICTORIA 1	Commercialization prohibited	Prohibited if payment	Prohibited	Prohibited	Null
CANADA 2	Opposed to the prohibition of surrogacy Commercialization prohibited	—	—	Prohibited	Legal, but null vis-à-vis surrogate mother
CANADA 5	Permitted for medical reasons on experimental basis	—	—	Permitted for surrogate mother for direct and indirect costs	—
ONTARIO 1	Regulation of contracts	Regulated	—	Permitted for surrogate mother if approved by court	Enforceable if approved by court

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy* (*Continued*)

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
QUEBEC 1	Surrogacy strictly forbidden	Prohibited	—	—	Null
QUEBEC 4	Prevent surrogacy agreements Commercialization prohibited	Prohibited	Forbidden	—	—
QUEBEC 5	Generally opposed to surrogacy Commercialization prohibited	Prohibited	Forbidden vis-à-vis intermediaries	—	—
QUEBEC 6	Surrogacy forbidden	Forbidden	Forbidden	—	—
COUNCIL OF EUROPE 1	Commercialization forbidden Member states may permit altruistic agreements	Forbidden (except medical services by physician in exceptional cases)	Forbidden	Forbidden	Null
FRANCE 5 FRANCE 4	Surrogacy prohibited	Prohibited	—	—	Null
GERMANY 1	Surrogacy prohibited	Prohibited	—	—	—
SPAIN 1	Surrogacy discouraged	—	—	—	—
UNITED KINGDOM 1	Commercialization prohibited	Prohibited if payment	Prohibited	Prohibited vis-à-vis intermediaries	Null

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy* (*Continued*)

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
UNITED KINGDOM 5	Commercialization prohibited	Prohibited for both profit and non-profit agencies (including professionals)	—	—	Null
UNITED KINGDOM 6	Surrogacy discouraged Commercialization prohibited	Prohibited vis-à-vis commercial agencies	—	—	Null
MICHIGAN 1	Commercialization prohibited	Prohibited if payment	—	Prohibited except reasonable expenses incurred by surrogate mother	Null
NEW YORK 2	Commercialization prohibited	Prohibited if payment (excludes physician's costs for AI and IVF)	—	Prohibited except reasonable expenses incurred by surrogate mother (affidavit setting out all payments received must be submitted to court), excluding loss of wages	Null

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy* (*Concluded*)

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
UNITED STATES 2	Opposed to legal prohibition Authorized for medical reason as clinical experimentation	Permitted if costs limited or professional services	—	Compensation for surrogate expenses and inconveniences, at least, is authorized; costs to intermediaries	—

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

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APPENDIX B

Proposed Contents of a Medically Assisted Procreation Act

Note

The following text is not intended to represent draft legislation on medically assisted procreation. It was put together in order to provide a comprehensive legislative approach to the control of most aspects of medically assisted procreation. In order to achieve such a goal we did not take into consideration the division of powers between the various levels of government. It is obvious that, within our constitutional framework, co-operative agreements between the federal, provincial and territorial governments would be necessary to put such control mechanisms in place. However, the details of such agreements would take us beyond the scope of this working paper. In order to provide as complete a text as possible, we had to be more affirmative than some of our recommendations, and we took the position that agreements between the different levels of government would be worked out.

Along with such agreements and legislation, provincial legislation would be necessary to deal with such issues as parentage and succession.

PROPOSED CONTENTS OF A MEDICALLY ASSISTED PROCREATION ACT

SHORT TITLE

1.

INTERPRETATION

2. In this Act,

"central registry"

"certification"

"certified clinic"

"counselling services"

"deposit"

"donation"

"embryos"

"gamete"

"genetic predisposition"

"genetic trait"

"import"

"inspector"

"medically assisted procreation"

"national agency"

etc.

DECLARATION OF PRINCIPLES

3. It is hereby recognized and declared that

(*a*) medically assisted procreation technologies should be developed and used in accordance with the fundamental principles of equality and justice and in a manner that respects the sanctity of life and the dignity and inviolability of the person;

(*b*) the use of medically assisted procreation technologies to select or avoid the transmission of genetic predispositions or traits is unacceptable except where specifically provided for;

(*c*) commercialization of medically assisted procreation is unacceptable;

(*d*) access to medically assisted procreation should not be limited on the basis of any criterion that relates to the family status, marital status or sexual orientation of the candidate;

(*e*) a person should have the opportunity through counselling services to be fully informed prior to making a decision to use a medically assisted procreation technology; and

(*f*) the establishment of standards for public safety in relation to the use of medically assisted procreation technologies is essential.

ACCESS TO MEDICALLY ASSISTED PROCREATION SERVICES

4. Limitation on Access

No one should be denied access to medically assisted procreation services, unless cost or scarcity of resources requires that candidates undergo a selection process. If a selection process is required, the family status, marital status or sexual orientation of the candidate should not be used as selection criteria.

GAMETES AND EMBRYOS

5. Possible Uses of Gametes and Embryos

(1) Gametes. The possible uses of gametes should be limited to fertilization, experimentation and destruction; however, fertilization should be prohibited beyond the time limit on freezing prescribed by regulation [recommendations 6(4) and 12(2)] and donated sperm should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus [recommendation 11].

(2) Embryos. The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing [recommendations 5(3) and 12(1)].

(3) Offence.

6. Selection of Gametes and Embryos

(1) Limits. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited [recommendation 2].

(2) Exception. However, such selection should be permitted when the objective is to prevent the transmission of serious genetic diseases [recommendation 2].

(3) Offence.

7. Commercialization

(1) Gamete and Embryo Donation. All commercialization of the donation of gametes and embryos should be prohibited [recommendation 3(1)].

(2) Exception. Only reimbursement of reasonable expenses incurred by donors should be permitted [recommendation 3(1)].

(3) Gamete and Embryo Banks. Gamete and embryo banks should not be permitted to operate on a profit basis [recommendation 3(2)].

(4) Exception. Banks should be allowed to be reimbursed for reasonable costs related to their operations [recommendation 3(2)].

(5) Offence.

8. Control over Gametes and Embryos in Case of Deposit and Donation

(1) Control over Gametes. Control over gametes should be vested in the person from whom the gametes are derived [recommendation 6(1)].

(2) Control over Embryos.

(*a*) Control over embryos should be vested in both partners, if each partner contributed gametes used to conceive the embryos;

(*b*) control over embryos should be vested in the partner genetically linked to the embryos, if only one partner contributed gametes used to conceive the embryos; and

(*c*) control over embryos should be vested in the bank or clinic in possession of the embryos, if the gametes used to create the embryos were both donated. [recommendation 5(2)].

(3) Deposit of Gametes.

(*a*) The person with control who wishes to deposit his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes;

(*b*) the statement must include provisions for the fate of the gametes in such circumstances as death of the person with control, abandonment of the parental project or expiry of the time limit on freezing; and

(*c*) the depositor should be able to change his or her stated intentions regarding the fate of the gametes by making a written statement to that effect before the gametes are used to create an embryo or used for any other intended purpose. [Recommendation 6(2)].

(4) Deposit of Embryos.

(*a*) Before conceiving an embryo for future personal use, the person with control should be required to make a written statement expressing his or her intentions as to the fate of the embryos. If control over the embryos is vested in both partners, their joint intentions are to be expressed in one written statement.

(*b*) The statement must include provisions for the fate of the embryo in such circumstances as death of the person or persons with control, abandonment of the parental project, expiry of the time limit on freezing, or divorce or other dispute between the persons with control.

(*c*) The person with control should be able to change his or her stated intentions regarding the fate of the embryo by making a written statement to that effect before the embryo is used for its intended purpose. If control over the embryo is vested in both partners, both must agree to any changes. [Recommendations 5(1) and (2)].

(5) Donation of Gametes.

(*a*) The person with control who wishes to donate his or her gametes should be required, before the donation is made, to make a written statement consenting to the donation and stating the conditions attached to his or her donation respecting the use of the gametes; and

(*b*) the donor should be able to withdraw his or her consent to the donation or change the conditions by making a written statement to that effect before the gametes are used to create an embryo or are used for another intended purpose. [Recommendation 6(3)].

(6) Donation of Embryo.

(*a*) The person with control who wishes to donate an embryo should be required, before the donation is made, to make a written statement consenting to the donation and should be able to attach to the statement conditions as to the use of the embryo. If control over the embryo is vested in both partners, their joint consent and conditions are to be expressed in one written statement.

(*b*) The donor should be able to withdraw his or her consent to the donation or change the conditions by making a written statement to that effect before the embryo is used for its intended purpose. If control over the embryo is vested in both partners, both must agree to the withdrawal of consent or any other changes. [Recommendation 5(4)].

(7) Offence.

9. Import of Gametes and Embryos

(1) Restriction. Importation of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should also meet established national standards [recommendation 14].

(2) Offence.

CLINICS AND BANKS

10. Restriction of Services

(1) Clinics. The application of medically assisted procreation technologies should be restricted to certified clinics [recommendation 21(2)].

(2) Banks. Only certified banks should be permitted to store gametes and embryos [recommendation 21(2)].

(3) Offence.

11. Counselling Services

Every clinic offering medically assisted procreation services should be required to provide counselling services whereby persons using these services may obtain information and assistance from psychologists, physicians or other experts, either before, during or after the technology is applied [recommendation 16].

12. Maintenance and Use of Records

(1) Obligation to Keep Records. Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties [recommendation 17(1)].

(2) Limit on the Information to Be Kept. Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care for the child; to meet the psychological needs of the child; to ensure proper clinical reports and to permit studies on the long-term effects of the various technologies used in medically assisted procreation [recommendation 17(2)].

(3) Protection of Confidentiality. Clinics should be responsible for protecting the confidentiality of the information they hold [recommendation 17(3)].

(4) Access to Information/Anonymity. The legal parents or the child should be able to request disclosure of non-identifying information such as social information (about the ethnic origin, profession, education, religious affiliation and interests of the donor, for example). However, identifying information should be disclosed only with the donor's consent [recommendation 18].

(5) Exception. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information about his or her medical or genetic history, for the purpose of a criminal prosecution related to such failure or false information [recommendation 19].

(6) Offence.

13. Annual Reports from Clinics

(1) Obligation to File Annual Reports. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry [recommendation 9].

(2) Content of Reports. The minimum content of the reports should be set by regulation and the data should be presented in the prescribed form [recommendation 9]. The clinics should also be required to document and justify the number of embryos implanted in each treatment cycle [recommendation 15].

(3) Offence.

NATIONAL AGENCY

14. Establishment of a National Agency

The federal, provincial and territorial governments, in conjunction with the professionals involved, should establish a national regulatory agency on medically assisted procreation [recommendation 22(1)].

15. Powers and Duties of Agency

(1) Establishment of Certification System. The national agency should establish a system of certification for clinics offering medically assisted procreation services and gamete and embryo banks [recommendation 21(1)].

(2) Regulations. The national agency should be empowered to make regulations [recommendation 22(2)(b)]

(*a*) prescribing the criteria for granting certification to a bank or clinic;

(*b*) establishing standards for the selection and screening of gamete and embryo donors [recommendation 10], and prescribing the maximum number of gametes that may be used from one donor [recommendation 13];

(*c*) establishing standards for the screening, storage [recommendation 10] and importation of gametes and embryos [s. 9];

(*d*) prescribing time limits respecting the freezing of gametes and embryos [[s. 5];

(*e*) respecting the prohibitions pertaining to the selection of gametes and embryos [s. 6] and to the commercialization of gamete and embryo donation [s. 7];

(*f*) respecting the reimbursement of costs incurred by donors and costs incurred by banks [s. 7];

(*g*) respecting the exercise of control over gametes and embryos, including the attachment of conditions to donation and the expression of intentions in the case of deposit [s. 8];

(*h*) respecting the composition and duties of counselling services established by clinics [s. 11];

(*i*) respecting the maintenance of records by clinics and the contents of the records [s. 12(1) and (2)];

(*j*) respecting the procedure for the release by clinics of identifying and non-identifying information about donors [s. 12(3) and (4)]; and

(*k*) respecting the content of annual reports submitted by clinics to the central registry [s. 13(1) and (2)].

(3) Additional Powers and Duties. The national agency should be given the following powers and duties:

(*a*) to take steps necessary to ensure compliance with the Act and regulations;

(*b*) to grant certification to a clinic or bank;

(*c*) to inspect certified clinics and banks [recommendation 22(2)];

(*d*) to amend, suspend or revoke the certification of a clinic or bank that fails to comply with the Act or regulations or with the terms of its certification [recommendation 22(2)];

(*e*) to establish a central registry which would collect annual reports from clinics and make available to the public the statistics derived from it;

(*f*) to analyse medically assisted procreation success rates and other information collected from the annual reports of clinics and compile statistics;

(*g*) to take steps necessary to prevent exploitation and commercialization in the area of medically assisted procreation;

(*h*) to promote research and studies in relation to medically assisted procreation technology, including research and studies aimed at reducing the number of multiple pregnancies, at developing technologies that follow the normal cycle of ovulation [recommendation 15] and at determining the long-term effects (medical and psychological) of medically assisted procreation technology on children born as a result of the technology [recommendation 20];

(*i*) to identify problems arising from medically assisted procreation on the basis of national data; and

(*j*) to advise governments on matters related to medically assisted procreation.

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